NORTH DAKOTA MEDICAID MANAGED CARE

MCO CONTRACT

CONTRACT BETWEEN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

AND

NORIDIAN MUTUAL INSURANCE COMPANY

FOR MANAGED CARE SERVICES

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1 PARTIES

THIS North Dakota Medicaid Managed Care Contract, is entered into by and between the North Dakota Department of Human Services (hereinafter referred to as the "Department"), whose address and phone number are:

State Capitol - Judicial Wing
600 E. Boulevard Ave.
Bismarck, ND 58505-0250
(701) 328-2310

and Noridian Mutual Insurance Company (hereinafter referred to as the "Contractor"), whose address and phone number are:

4510 13th Avenue SW
Fargo, ND 58121-0001
(701) 282-1539

A liaison for each party is identified in Section 25.

THE PARTIES AGREE AS FOLLOWS:

2 PURPOSE

The Department and Contractor have entered into this Contract for the purpose of providing and paying for Medicaid Covered Services to Enrollees in Contractor's plan under the Department's Medicaid program approved by the Secretary of the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

Contractor is an organization which, in consideration of periodic fixed payments, administers Covered Services to Enrollees. These Covered Services are provided by Contractor through an agreement (or agreements) with a health care services entity that has entered into contractual arrangements with Participating Providers, and who are employees or partners of Contractor or who have entered into a referral or contractual arrangement with Contractor.

3 TERM OF CONTRACT AND COMPLETION DATE

A. The term of this Contract for the purpose of delivery of Covered Services is from July 1, 2005, to June 30, 2006.

B. If the parties are involved in renegotiation or modification of this Contract, the Contract term may be extended by agreement of the parties prior to the end of the term.

C. Subject to the Contract termination provisions of Section 23, renegotiations may be extended for good cause, only at the end of the contract period, and for modification(s) during the contract period, if circumstances warrant, at the discretion of the state. Modification may be, but is not limited to, any change in state or federal law, rule, regulation, or policy affecting this contract.

4 SERVICES TO BE PROVIDED

Contractor, either directly or through Subcontractors, shall provide all of the Covered Services described in Section 2.2 of Attachment C in accordance with the provisions of this Contract, attachments to this Contract, and relevant laws and rules.

5 CONSIDERATION AND PAYMENTS

A. In consideration of the Covered Services provided through this Contract, the Department shall pay Contractor monthly payments based on the Capitation Rates specified in Attachment G. The monthly Capitation Rate for each aid category will be as specified in the attachment, and will be revised and updated Annually as specified in the attachment.

The rates are set prospectively and actuarially by the Department and agreed to by Contractor. The rates are not subject to further negotiation. The actuarial process incorporates Medicaid paid claims experience, eligible recipient months, cost-per-service trends, benefit adjustments, and utilization trends to formulate a fee-for-service per member per month rate. Managed care factors such as utilization and cost are introduced to create a managed care per member per month rate. The paid claims experience is the net of Third Party Liability (hereinafter referred to as "TPL") payments. The Department practices cost aversion in its policy of TPL and claims payments. The Department may adjust the rates for reasons including changes in the scope of Covered Services, changes in the design of the entire Medicaid managed care program, changes in the scope of administrative procedures, or changes in funding per Section 24. The Department may adjust the rates based on updated assumptions or more recent program experience, per Section 24. The Department may not change the Capitation Rates retrospectively, unless such changes are accepted by Contractor. The total amount paid to Contractor cannot

exceed the upper payment limit of what it would have cost the Department to provide the same services under fee-for-service to an actuarially equivalent population.

B. Payment to Contractor shall be based on Contractor enrollment data determined each month during the term of the Contract. Payment will be made on the first payment cycle of the month based on the number, age, sex, and eligibility category of those enrolled in Contractor's plan for the current month of coverage. The payment amount will be determined by the number of Enrollees in each age, sex, and eligibility category, multiplied times the respective Capitation Rate. In the event of an inconsistency between the Department's and Contractor's data, the lesser number will prevail until a reconciliation is made. Contractor will be responsible for detecting the inconsistency. Contractor shall notify the Department of any inconsistency between enrollment and payment data. The Department agrees to detect the source of the inconsistency. Except as provided in subsection F of this section, the Department will recoup overpayments or reimburse underpayments. The adjusted payment (representing reinstated Enrollees) for each month of coverage shall be included in the next monthly capitation payment, based on updated Contractor enrollment information for that month of coverage.

The Department will retroactively disenroll any newborn originally enrolled as TANF-eligible, but determined to be retroactively eligible for SSI within 6 months of birth, provided the Department makes necessary changes to the newborn's eligibility status within 12 months of birth. Contractor must remit to the Department all capitation payments made for such enrolled newborns. Contractor is responsible for notifying Providers who delivered Covered Services that Contractor is not responsible for payment and that each Provider must bill Medicaid. The Department will pay Providers for all Covered Services provided to such newborns according to Medicaid fee-for-service schedules and other payment rules.

C. The completion date of this Contract for final payment is the date upon which Contractor submits to the Department such final reports as are required by this Contract.

D. The consideration provided to Contractor under this Contract may be adjusted by the Department in its discretion based on any audit conducted in accordance with the terms of Section 8 and as provided for in Section 6 B (2).

E. Except as otherwise noted, Contractor shall actively pursue, collect, and retain all moneys from third-party payers for services to Enrollees covered under this Contract except where the amount of payment Contractor can

reasonably expect to receive is less than the estimated cost of recovery. Records shall be maintained of all third-party collections and reports submitted Quarterly to the Department's liaison in the format specified in Attachment K.

Collection from third-party payers is the responsibility of Contractor or its Subcontractors. Contractor and Subcontractors shall pursue collection from the third-party payer prior to any collection efforts directed toward the Enrollee, i.e., cases in which the Enrollee has already received payment from the third-party payer. The Contractor enrollment notification file sent monthly to Contractor by the Department will identify Enrollees who have third-party coverage. The Department will, upon request, assist Contractor in obtaining Enrollee cooperation regarding TPL recovery. In order to obtain the benefit of N.D.C.C. §§ 50-24.1-02(2), 50-24.1-02.1, and 50-24.1-08, Contractor is authorized to act as an agent of the Department in effecting collection from the third-party payer. Except for TPL recoveries as defined in this section, the Department continues to be responsible for all TPL requirements as described in 42 CFR § 433, Subpart D. The Department will continue to pursue casualty and estate recovery collections. Contractor may not pursue pharmacy, major medical, casualty, and estate recovery collections. Contractor and the Department will coordinate TPL recoveries made with respect to Enrollees who have received recoverable benefits provided both through Contractor and directly by the Department.

F. The Department will not recover from Contractor, payments to Contractor in the event the Department mistakenly reports to Contractor in the monthly enrollment notification file that an individual is enrolled in Contractor's plan. Only Department funds will be used to reimburse a payment made for an individual mistakenly enrolled with Contractor when the mistake is that the individual is not Medicaid-eligible.

The Department reserves the right to recover other types of inappropriate capitation payments, including untimely notice from Contractor to the Department of an Enrollee's request to disenroll, which had been submitted to Contractor.

6 SANCTIONS FOR FAILURE TO PERFORM

A. Sanctions may be imposed when Contractor acts or fails to act as follows:

(1) Substantially to provide Medically Necessary Services required under law or under this Contract, to an Enrollee covered under the Contract.

(2) Imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

(3) Acts to discriminate among Enrollees on the basis of their health status or need for health care services.

(4) Misrepresents or falsifies information that it furnishes to CMS or to the Department.

(5) Misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or health care Provider.

(6) Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210.

(7) Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

(8) Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

B. In the event Contractor fails to perform in accordance with the requirements of this Contract, and such failure shall not be cured within 30 Days after written notice thereof is given by the Department to Contractor, then the Department may, at its election:

(1) Suspend enrollment of new Enrollees in Contractor's plan or notify existing Enrollees of Contractor of noncompliance and provide an opportunity to disenroll from Contractor's plan. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the Contract completion date as provided under Section 3. The Department shall rescind such suspension if and when Contractor cures the default for which the suspension was imposed.

(2) Impose an appropriate or proportionate adjustment to payment levels if the default of Contractor involves the failure to provide one or more of the Covered Services required in Section 2.2 of Attachment C, or failure to make available any records or reports required under this Contract. Contractor may not elect to withhold any Medically Necessary Covered Services or hold Enrollees liable

for payments to Providers in order to receive adjusted payment levels.

(3) Impose civil money penalties in the following specified amounts.

(i) A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with Physician Incentive Plan requirements; or marketing violations.

(ii) A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the Department.

(iii) A maximum of $15,000 for each Medicaid-eligible individual the Department determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

(iv) A maximum of $25,000 or double the amount of excess charges, whichever is greater, for charging premiums or charges in excess of the amounts permitted under the Medicaid program.

(4) Appoint temporary management. Temporary management will be imposed if Contractor has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

(5) Grant Enrollees the right to terminate enrollment without good cause.

C. Before imposing any of the alternative sanctions, the Department must give Contractor written notice within 60 Days of the Department's knowledge of Contractor's failure to perform, that explains the basis and nature of the sanction, and any other due process protections that the Department elects to provide.

D. The remedies in this section are in addition to those provided under Section 23, Contract Termination, or additional sanctions allowed under North Dakota statute or regulation that address areas of noncompliance.

E. Suspension of payment for Enrollees enrolled after the effective date of the sanction will continue until CMS or the Department is satisfied that the

reason for imposition of the sanction no longer exists and is not likely to recur. Payments provided for under the Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS.

7 MEDICAL RECORDS

A. Contractor shall develop and keep such records as are required by law or other authority or as the Department determines are necessary or useful for assuring quality performance of this Contract.

B. Upon nonrenewal or termination of this Contract, Contractor shall turn over or provide copies to the Department, or to a designee of the Department, all documents, files, and records relating to persons receiving services and to the administration of this Contract that the Department may request. This provision does not apply to patient medical records.

C. Contractor shall provide the Department and its authorized agents with reasonable access to records Contractor maintains for the purposes of this Contract. The Department and its authorized agents will request access in writing except in cases of suspected fraud and abuse. Contractor must make all requested medical records, or copies of medical records, available at no cost to the Department within 21 Days of the Department's request, except when a Departmental review has been requested per Section 17 of this Contract, in which case Contractor must make all requested medical records available within 10 Days of the Department's request.

D. Contractor shall maintain the confidentiality of Enrollees records in conformance with Section 16 of this Contract.

8 AUDIT, ACCOUNTING, AND RETENTION OF RECORDS

A. Audit: Contractor, for purposes of audit, shall provide the state of North Dakota, the Secretary of the U.S. Department of Health and Human Services and his or her designated agent, and any other legally authorized governmental entity or their authorized agents access to all Contractor's materials and information pertinent to the services provided under this Contract, at any time during normal business hours, until the expiration of 6 years from the completion date of this Contract, as extended.

The Department and its authorized agents may record any information

and make copies of any materials reasonably necessary for the audit.

B. Accounting: Contractor shall maintain, for the purpose of this Contract, an accounting system of procedures and practices that conforms to generally accepted accounting principles.

C. Retention of Records: Contractor shall retain financial records, supporting documents, statistical records, and all other records supporting the services provided under this Contract for a period of 6 years from the completion date of this Contract. Contractor shall make the records available at all reasonable times at Contractor's general offices. The Department and its authorized agents will request access in writing except in cases of suspected fraud and abuse. Contractor must make all requested records available within 10 Days of the Department's request. If any litigation, claim, or audit is started before the expiration of the 6-year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved.

9 ASSIGNMENT, TRANSFER, AND SUBCONTRACTING

A. Contractor shall have no right to and shall not assign, transfer, delegate, or Subcontract this Contract or any right or duty arising under this Contract without the written approval of the Department. Notwithstanding the preceding sentence, the Department expressly allows Contractor to Subcontract its rights and duties under this Contract for the following:

(1) Referral management.

(2) Prior authorization.

(3) Quality management.

(4) Quality assurance.

(5) Appeals and grievances.

(6) Provider credentialing.

(7) Provider contracting.

Any additional duties Contractor may desire to Subcontract requires written approval of the Department.

The Department reserves the right to approve prototypes of Subcontracts,

in which case Contractor need not have each use of the prototype approved. The Department, in its discretion, may grant written approval of an assignment, transfer, delegation, or Subcontract; provided, however, that this paragraph shall not be construed to grant Contractor any right to such approval. Any Subcontracting arrangements must comply with selection and retention of providers, credentialing and recredentialing requirements, nondiscrimination and 42 CFR § 434.6(b) and (c); Sections of 42 CFR 438.6 that are appropriate services or activities delegated under the Subcontract; and 42 CFR 438.214.

B. Contractor must:

(1) Oversee functions and responsibilities delegated to Subcontractors.

(2) Evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

(3) Monitor the Subcontractor's performance on an ongoing basis and subject it to formal review.

(4) Identify Subcontractor deficiencies or areas for improvement, and ensure that corrective action is taken.

(5) Require a written agreement with Subcontractors that specifies the activities and report responsibilities delegated to the Subcontractor, and provide for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

C. In the event the Department approves of any assignment, transfer, delegation, or Subcontract, the assignment, transfer, delegation, or Subcontract must meet any conditions stated in the Department's written approval. The assignment, transfer, delegation, or Subcontract must be in writing and must contain all provisions required by this Contract or applicable laws and regulations. Copies of all such writings and revisions of writings must be submitted to the Department no later than 30 Days after the signing of this Contract. Subcontracts shall not terminate legal liability of Contractor under this Contract.

D. Department approval of any assignment, transfer, delegation, or Subcontract neither makes the Department a party to that agreement nor creates any right, claim, or interest in favor of any party to that agreement against the Department.

E. Contractor shall immediately notify the Department of any litigation

concerning any assignment, transfer, delegation, or Subcontract.

10 INDEMNITY

Contractor agrees to indemnify, protect, and save harmless the Department and its officers, agents, and employees from all liability, losses, injuries, damages, claims, demands, suits, fees (including attorney fees), costs, or judgments which result from or arise out of the activities of Contractor, its agents, or employees under this Contract, except to the extent based on the direct negligence of the Department or its officers, agents, or employees. Similarly, Contractor shall indemnify and hold the Department harmless, in accordance with the provisions of this Contract regarding indemnification, with respect to any suit or action by any party to an assignment, transfer, delegation, or Subcontract.

11 INSURANCE

Contractor shall secure, from an insurance company or government self-insurance pool authorized to do business in North Dakota, professional liability insurance or other coverage in the amount of at least $1,000,000 per claim and at least $3,000,000 per year covering its officers, employees, and agents for services provided under this Contract and naming the state of North Dakota, its officers, agents, and employees as an additional insured or covered party. Contractor shall furnish the Department with a certificate of insurance or other satisfactory proof of such coverage, including a copy of the endorsement naming the Department, its officers, agents, and employees as an additional insured or covered party. The endorsement shall contain a "Waiver of Subrogation" waiving any right of recovery the insurance company may have against the state of North Dakota. The endorsement shall also provide that coverage and endorsement may not be canceled or modified without 30 Days prior written notice to the Department, and that any attorney that represents the Department, its officers, agents, and employees pursuant to the policy or coverage must first qualify and be appointed by the North Dakota Attorney General as a special assistant attorney general.

Contractor's insurance coverage shall be primary (i.e., pay first) in respect to any insurance, self-insurance, or self-retention maintained by the state of North Dakota. Any insurance, self-insurance, or self-retention maintained by the state of North Dakota shall be in excess of Contractor's insurance and shall not contribute with it.

Any deductible amounts or other obligation under the policy or policies shall be the sole responsibility of Contractor.

The state of North Dakota shall be indemnified, saved, and held harmless to the full extent of any coverage actually secured by Contractor in excess of the minimum

requirements set forth in this section.

The insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe for, be placed with insurers rated "A" or better by the A.M. Best Company, Inc., and include:

A. Liability insurance (general, automobile, errors and omissions, and directors and officers coverage);

B. Fidelity bonding of persons entrusted with handling of funds;

C. Workers' compensation coverage for Contractor and Contractor's employees as may be required by N.D.C.C. Title 65, and as it may subsequently be amended, modified, or altered; and

D. Unemployment insurance.

12 FINANCIAL RESPONSIBILITIES OF THE CONTRACTOR

A. Contractor shall maintain financial reserves in compliance with appropriate rules and regulations of the state of North Dakota that apply to Contractor's line of business as established and administered by the North Dakota Department of Insurance. Contractor must provide assurances satisfactory to the Department showing that its provision against the Risk of insolvency is adequate to ensure that its Medicaid Enrollees will not be liable for Contractor's debts due to insolvency.

B. Contractor remains fully and solely responsible for all Contract obligations. Contractor shall notify the Department of any financial Risk imposed on Subcontractors, including Participating Providers, as part of the Subcontractor's responsibilities related to this Contract. The Department may monitor the amount of Risk assumed by Contractor and any Subcontractors.

C. Except as provided elsewhere in the Contract or any of its attachments, Contractor is fully and solely responsible for paying all Provider claims associated with the provision of Covered Services to plan Enrollees.

D. Contractor shall follow the appropriate rules and regulations of the state of North Dakota regarding insolvency that apply to a Contractor's line of business as established and administered by the North Dakota Department of Insurance. This includes the requirement that Contractor must hold harmless the Enrollee for any sums owed by Contractor and cover continuation of services to Enrollees for the duration of the period

for which payment has been made, as well as for inpatient admissions up until discharge.

E. Per 42 CFR § 417.479(a), Contractor may not make a specific payment directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual Enrollee.

Contractor's Physician Incentive Plans must comply with the requirements of 1903(m)(2)(A)(x) of the Social Security Act (42 U.S.C.§ 1396b(m)(2)(a)(x)). Contractor must disclose to the Department the information on the Contractor's Provider Incentive Plans listed in 42 CFR § 417.479(h)(1), 417.479(i), 422.208 and 422.210 at the times indicated at 42 CFR § 434.70(a)(3) in order to allow a determination of whether the incentive plans meet the requirements of 42 CFR § 417.479(d) - (g). Where applicable, Contractor must provide the capitation data required under 42 CFR § 417.479(h)(1)(vi) for the previous calendar year to the Department by April 1 of each year.

Contractor shall provide the information on its Physician Incentive Plans listed in 42 CFR § 417.479(h)(3) to any Enrollee, upon request.

F. Contractor must complete a HCFA Form 1513, Disclosure of Ownership and Control Interest Statement.

13 INDEPENDENT CONTRACTOR

A. Contractor assures the Department that Contractor is an independent contractor providing services for the Department and that neither Contractor nor any of Contractor's employees are employees of the Department under this Contract or any subsequent amendment.

B. Contractor is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, premiums, deductions, withholdings, overtime, and other amounts which may be legally required with respect to Contractor and the employment of all persons providing services under this Contract. In the event any Enrollee receiving services under this Contract is determined by any legal authority to be an employee of Contractor or the Department, this subsection shall apply to such Enrollee. Contractor agrees that the provision of this Contract regarding indemnification shall apply with respect to any and all claims, obligations, liabilities, cost, attorney fees, losses or suits accruing or resulting from: (1) Contractor's failure to comply with this subsection; or (2) from any finding by any legal authority or from claims by any employee

or alleged employee of Contractor that the person is an employee of the Department.

14 COMPLIANCE WITH APPLICABLE LAWS, RULES, AND POLICIES

Contractor in performing this Contract shall comply with all applicable federal and North Dakota laws, regulations, and written policies, including those pertaining to licensing.

Any provision of this Contract which is in conflict with federal Medicaid statutes, regulations, or HCFA policy guidance is hereby amended to conform to the provisions of these laws, regulations, and federal policy. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

15 FEDERAL REQUIREMENTS AND ASSURANCES

A. Contractor shall comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (7-97) which are applicable to Contractor. Contractor is responsible for determining which requirements and assurances are applicable to Contractor. Copies of the Form are available from the Department.

B. Contractor shall provide assurance to the Department that within the contracting service area, Contractor has the capacity to serve the expected enrollment including: (1) offering an appropriate range of services and access to Preventive Services and primary care services for the population expected to be enrolled in such service area; (2) maintaining a sufficient number, mix, and geographic distribution of Providers of services; (3) furnishing health services required by Enrollees appropriately and promptly; and (4) providing services which meet the Department's quality standards. Submission of the assurance, in a format specified by the Department, must be at the time Contractor enters into the Contract with the Department or at any time there has been a significant change in Contractor’s operations that would affect adequate capacity and services, including changes in services, benefits, geographic service area, payments, or enrollment of a new population.

C. Contractor may not knowingly have an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities in the following:

(1) As a director, officer, partner, or person with beneficial ownership of more than 5% of Contractor's equity; or

(2) Have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant to Contractor's contractual obligation with the Department.

Contractor shall certify to the Department that it meets these requirements prior to participating in the Medicaid program and at any time there is a changed circumstance from the last such certification. Contractor can rely on participants' certifications that they are currently not debarred for purposes of determining that persons meet these requirements.

D. Contractor shall comply with the Contractor assurances in Attachment A.

E. Contractor shall provide for the compliance of any Subcontractors with applicable federal requirements and assurances.

F. Contractor, as provided by 31 U.S.C. § 1352 and 45 § CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

G. Contractor shall submit to the Department a disclosure form as provided in 45 CFR § 93.110 and Appendix B to 45 CFR Part 93, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with this Contract.

H. Contractor shall comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act as amended, 42 U.S.C. § 1857, et seq.

I. Contractor shall comply with all applicable standards and policies relating to energy efficiency which are contained in the state of North Dakota Energy Plan issued in compliance with the federal Energy Policy and Conservation Act.

J. All hiring done in connection with this Contract must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. Contractor, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices.

K. The Department shall comply with conflict of interest safeguards as required by the Social Security Act Section 1932(d)(3) and 41 USC Section 423.

L. The Department, Contractor, and Subcontractors shall comply with Public Law 104-191 (Health Insurance Portability and Accountability Act of 1996) concerning the submission of claims using HIPPA compliant codes.

M. Contractor may not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

N. Submission of Encounter Data as required in Attachment K of this Contract will verify services have been actually provided.

16 CONFIDENTIALITY

Contractor shall, in accordance with relevant laws, regulations, and policies, including North Dakota Department of Human Services Manual Chapter 110-01, Confidentiality, protect the confidentiality of any material and information concerning an applicant for or Enrollee of services funded by the Department. Access to patient information, records, and data that identifies a particular Enrollee must be limited to the purposes outlined in 42 CFR § 434.6(a)(8) and confidentiality requirements in 45 CFR parts 160 and 164, subparts A and E.

17 RECIPIENT GRIEVANCES AND APPEALS

A. Statutory Basis and Definition

(1) Statutory Basis. This section is based on Sections 1902 (a)(3), 1902 (a)(4), and 1932 (b)(4) of the Social Security Act.

(2) The following definitions apply only to this Section 17.

(a) Action means:

(i) The denial or limited authorization of a requested service, including the type or level of service;

(ii) The reduction, suspension, or termination of a previously authorized service;

(iii) The denial, in whole or in part, of payment for a service;

(iv) The failure to provide services in a timely manner;

(v) The failure of Contractor to act within the described timeframes; or

(vi) For a resident of a rural area with only one MCO, the denial of a Medicaid Enrollee's request to exercise his or her right, under Section 438.52 (b)(2)(ii), to obtain services outside the Network.

(b) Appeal means a request for review of an action, as "action" is defined in this section.

(c) Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the Contractor level and access to the Department's fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights.)

B. General Requirements

(1) Contractor must have a system in place for Enrollees that includes a grievance process, an appeals process, and access to the Department's fair hearing system.

(2) Filing requirements.

(a) Authority to file.

(i) An Enrollee may file a grievance and a Contractor level appeal, and may request a Department fair

hearing.

(ii) A Provider, acting on behalf of the Enrollee and with the Enrollee's written consent, may file an appeal. A Provider may file a grievance or request a Department fair hearing on behalf of an Enrollee.

(b) Timing. An Enrollee may file an appeal within 90 Days from the date on the notice of action. Within that timeframe, the Enrollee or the Provider may file an appeal; and the Enrollee may request a Department fair hearing.

(c) Procedures.

(i) The Enrollee may file a grievance either orally or in writing with either the Department or Contractor.

(ii) The Enrollee or the Provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

C. Notice of Action

(1) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Attachment C, Section II, 2.15 Information Requirements of this Contract.

(2) Content of notice. The notice must explain the following:

(a) The action Contractor or Subcontractor has taken or intends to take.

(b) The reasons for the action.

(c) The Enrollee's or the Provider's right to file an appeal.

(d) The Enrollee's right to request a Department fair hearing.

(e) The procedures for exercising the rights to an appeal or grieve.

(f) The circumstances under which expedited resolution is available and how to request it.

(g) The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services.

(3) Timing of notice. Contractor must mail the notice within the following timeframes:

(a) For termination, suspension, or reduction of previously authorized Medicaid-Covered Services, within 10 Days before the date of the action, except as permitted under 42 CFR 431.213 and 431.214.

(b) For denial of payment, at the time of any action affecting the claim.

(c) For standard service authorization decisions that deny or limit services, within 14 calendar Days following the receipt of the request for service.

(d) If the timeframe is extended, Contractor must:

(i) Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file an grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires an no later than the date the extension expires.

(e) For service authorization decisions not reached within the specified timeframes (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(f) For expedited service authorization decisions:

(i) For cases in which a Provider indicates, or Contractor determines, that the following standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition

requires and no later than 3 working Days after receipt of the request for service.

(ii) Contractor may extend the 3 working Days time period by up to 14 calendar Days if the Enrollee requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Enrollee's interest.

D. Handling of Grievances and Appeals

(1) General requirements. In handling grievances and appeals, Contractor must meet the following requirements:

(a) Give Enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) Acknowledge receipt of each grievance and appeal.

(c) Ensure that the individuals who make decisions on grievances and appeals are individuals:

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.

(A) An appeal of the denial that is based on lack of Medical Necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) Any grievance or appeal involving clinical issues.

(2) Special requirements for appeals. The process for appeals must:

(a) Provide that oral inquiries seeking to appeal an action are

treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the Enrollee or the Provider requests expedited resolution.

(b) Provide the Enrollee a reasonable opportunity to present evidence, and allegations or fact or law, in person as well as in writing. (Contractor must inform the Enrollee of the limited time available for this in the case of expedited resolution.)

(c) Provide the Enrollee and his or her representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(d) Include, as parties to the appeal:

(i) The Enrollee and his or her representative; or

(ii) The legal representative of a deceased Enrollee's estate.

E. Resolution and notification: Grievances and appeals.

(1) Basic rule. Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within timeframes that may not exceed the timeframes specified in this section.

(2) Specific timeframes.

(a) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe may not exceed 90 Days from the day Contractor receives the grievance.

(b) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the timeframe may not exceed 45 Days from the day Contractor receives the appeal. This timeframe may be extended under paragraph E (3) of this section.

(c) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the timeframe may not exceed 3 working Days after Contractor receives the

appeal. This timeframe may be extended under paragraph E (3) of this section.

(3) Extension of timeframes.

(a) Contractor may extend the timeframes for standard resolution of appeals and expedited resolution of appeals by up to 14 calendar Days, if:

(i) The Enrollee requests the extension; or

(ii) Contractor shows there is need for additional information and how the delay is in the Enrollee's interest.

(b) Requirements following extension. If Contractor extends the timeframes, it must for any extension not requested by the Enrollee, give the Enrollee written notice of the reason for the delay.

(4) Format of notice.

(a) Grievances:

(i) Contractor must provide written notice of disposition.

(ii) For notice of an expedited resolution, Contractor must also make reasonable efforts to provide oral notice.

(b) Appeals:

(i) Contractor must provide written notice of disposition.

(ii) For notice of an expedited resolution, Contractor must also make reasonable efforts to provide oral notice.

(5) Content of notice of appeal resolution. The written notice of resolution must include the following:

(a) The results of the resolution process and the date it was completed.

(b) For appeals not resolved wholly in favor of the Enrollees:

(i) The right to request a Department fair hearing, and

how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the Enrollee may be held liable for the cost of those benefits if the hearing decision upholds Contractor's action.

(6) Requirements for Department fair hearings.

(a) Availability. The Enrollee can request a Department fair hearing 30 Days from the date of Contractor's notice of action or 30 Days from the date of the appeal resolution notice.

(b) Parties. The parties to the Department fair hearing include Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

F. Expedited Resolution of Appeals

(1) General rule. Contractor must establish and maintain an expedited review process for appeals, when Contractor determines (for a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

(2) Punitive action. Contractor must ensure that punitive action is neither taken against a Provider who requests an expedited resolution or supports an Enrollee's appeal.

(3) Action following denial of a request for expedited resolution. If Contractor denies a request for expedited resolution of an appeal, it must:

(a) Transfer the appeal to the timeframe for standard resolution.

(b) Make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within 2 calendar Days with a written notice.

G. Information About the Grievance System To Providers and Subcontractors. Contractor must provide the following information about the grievance process, appeals, and Department fair hearings to all Enrollees, and Providers and Subcontractors at the time they enter into a contract:

(1) For state fair hearing:

(a) The right to hearing;

(b) The method for obtaining a hearing; and

(c) The rules that govern representation at the hearing.

(2) The right to file grievances and appeals.

(3) The requirements and timeframes for filing a grievance or appeal.

(4) The availability of assistance in the filing process.

(5) The toll-free numbers that the Enrollee can use to file a grievance or an appeal by phone.

(6) The fact that, when requested by the Enrollee:

(a) Benefits will continue if the Enrollee files an appeal or a request for Department fair hearing within the timeframes specified for filing; and

(b) The Enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Enrollee.

H. Record Keeping and Reporting Requirements

(1) Contractor must maintain records of grievances and appeals. A record keeping system for informal (verbal) grievances in the form of a written “log” which includes a short, dated summary of the problem, the response, and the resolution.

(2) A record keeping system for formal (written) grievances which includes a copy of the original grievance, the response, the resolution, and the date of the Quarterly report that was sent to the Department and that included a summary of the grievance.

(3) Per Section 4.1 of Attachment C, Contractor shall submit to the Department a Quarterly report summarizing each grievance handled during the quarter.

I. Continuation of Benefits While the Contractor Appeal and the Department Fair Hearing Are Pending

(1) Terminology. As used in this subsection, "timely" filing means filing on or before the later of the following:

(a) Within 10 Days of Contractor mailing the notice of action.

(b) The intended effective date of Contractor's proposed action.

(2) Continuation of benefits. Contractor must continue the Enrollee's benefits if:

(a) The Enrollee or the Provider files the appeal timely;

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) The services were ordered by an authorized Provider;

(d) The original period covered by the original authorization has not expired; and

(e) The Enrollee requests extension of benefits.

(3) Duration of continued or reinstated benefits. If, at the Enrollee's request, Contractor continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

(a) The Enrollee withdraws the appeal.

(b) Ten Days pass after Contractor mails the notice, providing the resolution of the appeal against the Enrollee, unless the Enrollee, within the 10 Day timeframe, has requested a Department fair hearing with continuation of benefits until a Department fair hearing decision is reached.

(c) A Department fair hearing office issues a hearing decision adverse to the Enrollee.

(d) The time period or service limits of a previously authorized service has been met.

(4) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the Enrollee, that is, upholds Contractor's action, Contractor may recover the cost of the services furnished to the Enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 431.230 (b).

J. Effectuation of Reversed Appeal Resolutions

(1) Services not furnished while the appeal is pending. If Contractor, or the Department fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.

(2) Services furnished while the appeal was pending. If Contractor, or the Department fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, Contractor or the Department must pay for those services, in accordance with Department policy and regulations.

K. Policies and Procedures

The Department must approve Contractor's grievance and appeal policies and procedures in writing.

L. Department Fair Hearing

If the Enrollee requests a State fair hearing, the Department must grant the Enrollee a State fair hearing according to North Dakota Administrative Code chapter 75-01-03, Appeals and Hearings and North Dakota Century Code chapter 28-32, Administrative Agencies Practices Act.

18 PUBLICITY AND MARKETING

Contractor must submit to the Department for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan. Contractor must market to the entire service area under the Contract. The Department shall keep

Contractor's marketing plan confidential. The Department will review these materials and approve or disapprove them within 30 Days. Contractor agrees to engage only in marketing activities which are preapproved in writing. However, problems and errors subsequently identified by the Department must be corrected by Contractor. Mistakes in written material must be corrected at the time of the next printing. Contractor may make approved Contractor marketing materials available and station marketing representatives at county office sites, at the local county offices' discretion. In addition, Contractor may work with the Department's managed health care administrator to make marketing material available to Enrollees and Potential Enrollees. All marketing materials and activities must comply with the specifications outlined in Attachment B.

19 PATENTS AND COPYRIGHTS

A. All patent and other legal rights in and to inventions arising out of activities assisted by funds from this Contract must be available to the public for royalty-free and nonexclusive licensing. Contractor shall notify the Department promptly, in writing, of any invention conceived or actually reduced to practice in the course of performance of this Contract.

B. The Department and any federal agency from which funds for this Contract are derived shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use and authorize others to use for Department and agency purposes any written, audio, or video material developed under this Contract.

20 TECHNICAL ASSISTANCE

The Department may furnish within a reasonable time technical administrative or program assistance that is requested, in writing, by Contractor and that the parties agree is necessary to Contractor's performance. This assistance may include providing copies of regulations, statutes, standards, and policies which must be complied with under this Contract. The Department may supply essential interpretations of such materials and this Contract to assist with Contract compliance by Contractor. Contractor shall not be relieved by a request for technical assistance of any obligation to meet the requirements of this Contract. Legal services will not be provided by the Department to Contractor in any matters relating to this Contract.

21 ACCESS TO PREMISES

Contractor shall provide the State of North Dakota, the Secretary of the U.S. Department of Health and Human Services and his or her designated agent, and any other legally authorized governmental entity or their authorized agents the right to enter

at all reasonable times Contractor's premises or other places where work under this Contract is performed to inspect, monitor, or otherwise evaluate work performed. Contractor shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties. The Department and its authorized agents will request access, in writing, except in case of suspected fraud and abuse. All inspection, monitoring, and evaluation must be performed in such a manner as not to unduly interfere with the work being performed under this Contract.

22 RELATED PARTY TRANSACTIONS

Contractor shall not enter into any agreements with a third party for the use, purchase, sale, lease, rental, or similar transaction involving personal property, real property or services purchased with funds derived from the Contract wherein there would be pecuniary or other valuable benefit for an employee, administrator, officer, or director of Contractor's corporation. The Department may grant exceptions to this prohibition where it determines that the particular circumstances warrant the granting of an exception. Contractor must request a waiver of this prohibition in writing. The Department must issue its decision to Contractor in writing.

Notwithstanding anything to the contrary stated herein, this section shall not be construed or deemed to preclude or limit the ability of Contractor to enter into agreements or Subcontracts with entities that are directly or indirectly controlled by Contractor, or that are direct or indirect subsidiaries or affiliates of Contractor, providing Contractor otherwise complies with Section 9 of this contract regarding assignments, transfers, delegations, and Subcontracts.

23 CONTRACT TERMINATION

A. The Department, by written notice to Contractor, may at any time immediately terminate the whole or any part of this Contract if Contractor:

(1) Allows patient safety to be at risk;

(2) Loses a certificate of authority;

(3) Applies for or consents to the appointment of a receiver, trustee, or liquidation for itself, or any of its property;

(4) Admits in writing that it is unable to pay its debts as they mature;

(5) Assigns for the benefits of creditors;

(6) Commences a proceeding under bankruptcy, reorganization,

insolvency, or readjustment of a debt provision of federal or North Dakota law or answer admitting the material allegations of a petition filed against Contractor in any such proceeding;

(7) Is subject to an involuntary proceeding under any bankruptcy, reorganization, insolvency, or readjustment of a debt provision of federal or North Dakota law not dismissed within 60 Days; or

(8) Is found to be out of compliance with the provisions expressed in Section 15, subsection C. The Department may continue this Contract, unless otherwise directed by the Secretary of the U.S. Department of Health and Human Services, but may not extend or renew the Contract.

B. (1) An event of default shall be established under this Contract if Contractor fails to:

(a) Perform the services within the time limits specified in this Contract;

(b) Perform any requirement of either this Contract or the 1997 Balanced Budget Act;

(c) Perform its contractual duties or responsibilities specified in the standards of Contractor performance defined in the Contract;

(d) Comply with any law, regulation, or licensure and certification requirement including the requirements in Sections 1932, 1903(m) and 1905(t) of the Social Security Act; or

(e) Comply with the restrictions and limitations placed on Contractor activities under this Contract and its attachments.

(2) If Contractor does not cure any of the foregoing events of default within 30 Days after written notice of such default is given by the Department to Contractor, the Department may at any time thereafter immediately terminate the whole or any part of the Contract by written notice to Contractor; provided, however, that if the event of default is such that it cannot be cured within said 30-Day period, Contractor shall not be deemed in default if Contractor diligently pursues such curative action to completion.

(3) The Department's notice of default shall inform Contractor that

Contractor is entitled to a hearing concerning the notice of default, provided under N.D. Admin. Code § 75-01-03-03(3) and 42 U.S.C. § 1396u-2(e)(4)(B), if Contractor submits, within 10 Days of receipt of the notice of default:

(a) A statement of the disputed facts, if any; and

(b) The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

C. The remedies in this section are in addition to any other remedies provided by law or the terms of this Contract.

D. Upon termination or nonrenewal of this Contract, Contractor shall allow the Department, its agents, and representatives, full access to Contractor's facilities and records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid claims. Contractor shall also work with the Department to arrange the transfer of responsibility for the care of Enrollees with ongoing treatment plans. When termination of the Contract occurs, the following obligations must be met by the parties:

(1) Where this Contract is terminated due to default by Contractor:

(a) The Department shall be responsible for notifying all Enrollees of the date of termination, the process by which the Enrollees can continue to receive services or Enrollees rights to disenroll immediately without cause;

(b) Contractor shall be responsible for all expenses related to said notification; and

(c) The Department may prorate the capitation payments if termination date falls in the middle of the month.

(2) Where this Contract is terminated for any reason other than default by Contractor:

(a) The Department shall be responsible for notifying all Enrollees of the date of termination, the process by which the Enrollees can continue to receive services, or Enrollees rights to disenroll immediately without cause;

(b) The Department shall be responsible for all expenses relating to said notification; and

(c) The Department may prorate the capitation payments if termination date falls in the middle of the month.

(3) Where this Contract is terminated for any reason Contractor shall pay for Medically Necessary Covered Services provided to Enrollees through the end of the month of the effective date of termination or through discharge from an inpatient facility, whichever date is later.

E. The Department may terminate this Contract, as provided in Section 24, "Availability of Funding and Updating Rates." The Department shall give notice to Contractor at least 30 Days prior to the effective date of termination.

F. Before terminating this Contract, the Department must provide Contractor a predetermination hearing.

G. The Department or Contractor may terminate this Contract without cause after giving written notice to the other party's liaison at least 60 Days prior to the effective date of termination.

24 AVAILABILITY OF FUNDING AND UPDATING RATES

A. The Department may terminate at any time the whole or any part of this Contract, or propose modifications to the terms of the Contract, if either:

(1) Federal or state of North Dakota funding for the Contract or for the Medicaid program as a whole is reduced or terminated for any reason; or

(2) The appropriation from the state of North Dakota budget for the Medicaid program or the Department is reduced or there is an across-the-board budget reduction affecting the Department.

Modifications of the Contract include reduction of rates or amounts of consideration, reduction in scope of Covered Services, or the alteration of the manner of performance in order to reduce expenditures under the Contract.

The Department may adjust the rates based on updated assumptions or more recent program experience.

B. If the Department elects to terminate the Contract for the reasons set forth

in subsection A of this section, it shall give written notice thereof to Contractor at least 30 Days prior to the date of such termination.

C. In the event the Department elects to propose modifications to the terms of the Contract as provided above, based on either reductions in funding or updates in the assumptions underlying the rates or more recent program experience, then the Department shall provide Contractor with those Contract modifications, including Capitation Rate revisions it would deem acceptable.

D. Contractor shall have a minimum of 60 Days to review the proposed Contract modifications and to notify the Department in writing whether the Contract modifications are acceptable. Notwithstanding any other provision of this Contract, Contractor shall have the right to terminate this Contract if the Contract modifications are deemed insufficient or unacceptable by Contractor.

During the period Contractor is reviewing the proposed modifications, the Department will reimburse Contractor at the higher of the new or current Capitation Rates for such period and until either the proposed modifications are accepted by Contractor or the Contract is terminated, and during such period Contractor will be held to the terms of the executed Contract.

25 LIAISON AND SERVICE OF NOTICES

A. Liaisons for the Department and Contractor are identified in Attachment P.

These persons will serve as the primary contacts between the parties regarding the performance of the Contract. If these persons should change, the other party to this Contract should be notified within 3 business days.

B. Written notices, reports, and other information required to be exchanged between the parties must be directed to the liaison at the parties' addresses set out in this Contract.

26 WAIVER

Waiver of any default, breach, or failure to perform under this Contract is not deemed to be a waiver of any subsequent default, breach, or failure of performance. In addition, waiver of any default, breach, or failure to perform is not construed to be a modification of the terms of this Contract unless reduced to writing as an amendment to this Contract.

27 SCOPE, AMENDMENT, AND INTERPRETATION OF CONTRACT

A. This Contract consists of the Contract Table of Contents and the Contract provisions on numbered pages, and Attachments A through O.

This is the entire Contract between the parties.

B. In the event of a dispute as to the duties and responsibilities of the parties under the Contract, the Contract provisions will govern over any attachments.

C. No statements, promises, or inducements made by either party or their agents are valid or binding if not contained herein.

D. No contractual provisions from a prior contract of the parties are valid or binding in this Contractual agreement.

E. This Contract may be enlarged, modified, or altered only by written amendment signed by the parties to this Contract.

The parties through their authorized agents have executed this Contract on the dates set out below.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

By: _____ Date _____
Carol K. Olson, Executive Director

By: _____ Date _____
David J. Zentner, Director
Medical Services Division

By: _____ Date _____
Krista Andrews
Contract Officer

NORIDIAN MUTUAL INSURANCE COMPANY

By: _____ Date _____

Michael B. Unhjem
President and CEO

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ATTACHMENT A

CONTRACTOR ASSURANCES

A. This Contract shall be construed according to the laws of the state of North Dakota. In connection with the furnishing of supplies or performance of work under this Contract, Contractor is obligated and agrees to comply with all local, North Dakota, and federal laws, regulations, and executive orders related to the performance of this Contract including but not limited to the following: Fair Labor Standards Act, Equal Pay Act of 1963, Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act of 1990, the North Dakota Human Rights Act, the Drug Abuse Prevention Treatment and Rehabilitation Act of 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992, the Pro-children Act of 1994, the Drug-free Workplace Act of 1988, and Title IX of the Education Amendments of 1972 (regarding education programs and activities). Questions regarding the provision of services according to these Acts may be directed to Krista Andrews, Contract Officer, North Dakota Department of Human Services, Judicial Wing, State Capitol, 600 E. Boulevard, Bismarck, ND 58505 (701-328-2311 or 701-328-3975 TDD).

B. Contractor will not, except upon the written consent of the affected individual or their responsible parent, guardian, or custodian, use or cause to be used any information concerning such individual for any purpose not directly connected with the parties' responsibilities with respect to services purchased hereunder.

C. Unless otherwise authorized by federal law, the charges to be made by Contractor do not include costs financed by federal monies other than those generated by this Contract.

D. Contractor shall not assign this Contract.

E. Contractor certifies by signing this Contract that neither Contractor, Subcontractors, nor their principals, are presently debarred, declared ineligible, or voluntarily excluded from participation in transactions with the state of North Dakota or federal government by any department or agency of the federal government. This part of the Contractor assurances is in accordance with Executive Order 12549 and Part 76 of 45 CFR.

F. Contractor assures that:

1) No federal funds from this Contract will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an

officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2) If any Contract funds other than federal funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

ATTACHMENT B: MARKETING GUIDELINES
NORTH DAKOTA MEDICAID MANAGED CARE PROGRAM

For purposes of this attachment, the following definitions apply:

Direct Marketing Materials: All mediums, including brochures and leaflets; newspaper, magazine, radio, television, billboard and yellow pages advertisements; and presentation materials used by Contractor representatives.

Medicaid-specific Marketing: Any materials mailed to, distributed to, or aimed at Potential Enrollees specifically, and any material that mentions Medicaid or Title XIX.

Cold Call Marketing: Any unsolicited personal contact by Contractor with a Potential Enrollee for the purpose of marketing as defined in this attachment.

Marketing: Any communication, to a Potential Enrollee who is not enrolled with Contractor, that can reasonably be interpreted as intended to influence the Potential Enrollee to enroll in the Contractor's plan, or either to not enroll in, or to disenroll from another plan.

The Department has established the following set of guidelines for Contractor marketing activities under the state of North Dakota Medicaid program. These were designed to allow Contractor to educate Potential Enrollees about their plans, while protecting Enrollees from abusive marketing practices. Contractor may conduct general, non-Medicaid advertising. Direct marketing will be permitted on a limited basis, subject to Department review and approval of the content. The following activities are expressly forbidden:

X Contractor may not assert or imply that an Enrollee will lose Medicaid benefits if he or she does not enroll in Contractor's plan.

X Contractor may not discriminate (in marketing to or during the course of enrollment) against any eligible individual on the basis of health status, past medical utilization, or need for future health care services.

X Contractor may not market or advertise a benefit of service unless it is clearly specified in the Contract or unless it is a Special Program offered by Contractor, per Section 5.5 of Attachment C.

X Marketing materials cannot contain false and materially misleading information.

X The plan cannot offer other insurance products as inducement to enroll.

X The plan must not commit marketing fraud and must comply with federal

requirements for provision of information including accurate oral and written information sufficient for the beneficiary to make an informed decision whether or not to enroll.

The table below presents the basic parameters for Contractor marketing.

Type of Marketing Activity	**Permitted, Dept. Approval Not Needed**	**Permitted, With Dept. Approval**	**Not Permitted**
General, non-Medicaid advertising	X		
General, Medicaid-specific advertising		X	
Medicaid-specific advertising in current care sites		X	
Provider correspondence to all Medicaid patients of record about Contractor options		X	
Client-initiated requests for phone conversation with Contractor staff	X		
Client-initiated one-on-one meetings with Contractor staff prior to enrolling	X		
Mailings by Contractor in response to client requests		Xi	
Unsolicited Contractor mailings to clients		X	
Contractor group meetings (held at Contractor or public facility)		X	

i Mailings must include adequate written description of Contractor's rules, procedures, benefits, services, and other information.

Contractor group meetings (held in private clubs, churches, homes or other private sites)			X
Individual solicitation, public settings			X
Individual solicitation, residences			X
Gifts, cash incentives, or rebates (anything other than written information about Contractor or general health education information to potential clients			X

Type of Marketing Activity	**Permitted, Dept. Approval Not Needed**	**Permitted, With Dept. Approval**	**Not Permitted**
Gifts to clients after they enroll, simply because they enroll			X
Gifts to clients (e.g. baby T-shirt showing immunization schedule) based on specific health events unrelated to enrollment		X	
Food to potential clients at meetings		X	
Marketing or advertising a benefit or service that is not clearly specific in the contract			X
Directly or indirectly engage in door-to-door, telephone, or other cold-call marketing activities			X

ATTACHMENT C: CONTRACT TERMS FOR MCOs

SECTION I - DEFINITIONS

1.1 Definitions

The following terms and definitions apply to this Contract and all of its attachments.

Aid to Families with Dependent Children (AFDC) - A program that provides cash assistance for low income children and their caretakers. In effect through June 30, 1997. See, Temporary Assistance for Needy Families (TANF).

Annual - Unless otherwise specified in the Contract, annual means the 12 months of the Department's fiscal year ending June 30.

Capitation Rate - The fee the Department pays monthly to Contractor for the provision of Covered Services to each Enrollee. The fee is reimbursed whether or not the Enrollee received services during the month for which the fee is intended. The fee may vary by age, eligibility category, and region.

Centers for Medicare and Medicaid Services (CMS) – The federal agency responsible for administering Medicaid.

Children - Individuals under 21 years of age.

Claim – Means

(1) A bill for service;

(2) A line item of service; or

(3) All services for one enrollee with a bill.

Clean Claim – A claim that can be processed without obtaining additional information from the Provider of the service or from a Third Party. It includes a claim with errors originating in a payer's system. It doe not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

CLIA Clinical Laboratory Improvement Amendments.

Clinic Services - Those services provided by a regional Human Service Center.

Community-based Organizations - Local governmental and nonprofit organizations providing programs of Preventive and other health related Services. Community-based Organizations provide services that include: child immunizations, health education, case management, health screening, nutrition, poison prevention, developmental outpatient and health support services, and health tracking programs.

Contract – This Contract including all attachments, between the Department and Contractor.

Contractor – Noridian Mutual Insurance Company, a North Dakota nonprofit mutual insurance company.

Course of Treatment - One or more Covered Services which Contractor or its Participating Providers authorizes to treat a specific medical condition. Contractor may limit a Course of Treatment to a specific period of time or units of service within medically accepted standards.

Covered Services - Those services which Contractor is required to provide under this Contract as specified in Section 2.2 of this attachment.

DHHS - The United States Department of Health and Human Services.

Date of Payment – The date of the check or other form of payment.

Date of Receipt – The date the claim is received, as indicated by its date stamp on the claim.

Day - Except where the term "working Days" or "business Days" is expressly used, all references in this Contract will be construed as calendar Days.

Department - The North Dakota Department of Human Services.

Department Fiscal Year – See, Fiscal Year.

Division of Medical Services - A division in the Department which administers the Medicaid program.

Emergency Care - A medical condition which most non-medical people think is life-threatening or could cause death or severe, permanent damage or injury to a person or unborn baby if not treated immediately.

Emergency Medical Condition - Defined as, but not limited to, a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of

health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

Emergency Room Screen - A medical screening examination within the capability of the emergency facility to determine whether an Emergency Medical Condition exists or active labor is occurring.

Emergency Services - Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish emergency services; and needed to evaluate or stabilize an Emergency Medical Condition.

Encounter Data - Comprehensive data on Enrollees' medical services. The data includes demographic information as well as procedures and diagnoses identified by their CPT-IV, ICD-9, revenue codes, DRGs, and service dates.

Enrollee – An individual who has been certified Medicare eligible by the Department as eligible to enroll with Contractor, and whose name appears on the Contractor enrollment notification file which the Department will transmit to Contractor every month in accordance with an established notification schedule, per Attachments F and H.

Enrollment Area - The county or counties in which Contractor is licensed to operate by the state of North Dakota and in which Contractor has service capability as required by the Department and set forth in this Contract.

EPSDT – See, Health Tracks.

Fiscal Year - The period, which begins July 1 and ends June 30 of the following calendar year, used by the Department for accounting purposes. The federal fiscal year begins October 1 and ends September 30 of the following calendar year.

FQHC – Federally Qualified Health Center.

HCFA - The Health Care Financing Administration, a division within the federal Department of Health and Human Services.

Health Tracks – A Medicaid program of health screening and necessary diagnostic and treatment services for all Children under age 21 who are eligible for Medicaid.

MCO - Managed Care Organizations are:

(1) Health Maintenance Organizations ("HMO") as set forth in N.D.C.C. Ch. 26.1-18.1.

(2) Provider Sponsored Organizations ("PSO") as set forth in N.D.C.C. Ch. 26.1-01-07.6 and N.D. Admin. Code Ch. 45-06-13.

(3) Health Insuring Organization ("HIO") means an entity that in exchange for capitation payments, covers services for Enrollees through payments to, or arrangements with, Providers.

MCO/Health Tracks (ESPDT) Policies and Procedures - Contract attachment D establishing criteria for how continuing care Providers under Health Tracks must operate.

Medicaid - A medical assistance program operated by the Department under Title XIX of the Social Security Act and related regulations, and N.D.C.C. Ch. 50-24.1 and related rules.

Medicaid Interim Rate - The rate Medicaid pays for each visit of a Medicaid Enrollee to a federally qualified health center or certified rural health clinic. The rate is Provider specific and updated Annually by the Department.

Medical Necessity - The need for a Medically Necessary Service.

Medically Necessary Service - Medical care and treatment that is:

a. Appropriate for symptoms present and is consistent with the diagnosis, if any;
b. Provided according to generally accepted medical practice and professionally recognized standards;
c. Not generally regarded as experimental or investigational; and
d. Specifically allowed by the licensing laws which apply to the Provider of the service.

Networks – See, Primary Care Network.

Participating Provider - Any individual or facility providing medical care that has entered into a contract with Contractor. Participating Providers are a type of Subcontractor for the purposes of Section 9 of the Contract.

Physician Incentive Plans - Any compensation arrangement between Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid Enrollees enrolled with Contractor.

Post-stabilization Care Services - Covered Services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition.

Potential Enrollee – A Medicaid eligible individual who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of Contractor or any other Medicare plan.

Poverty Level Individuals - Includes:

a. Pregnant women and children (ages 0 through 5 years) at or below 133% of the federal poverty level; and
b. Children (ages 6 to 19) at or below 100% of the federal poverty level.

Preventive Services - Comprehensive services that emphasize prevention, early detection and early treatment of conditions, and that include routine physical examinations, immunizations, smoking cessation programs, prenatal education programs, mammograms, and well person care.

Prior Authorization - Approval to provide medical services, granted prior to those services being provided, for payment purposes by Contractor for its active Enrollees.

Primary Care Network – A defined group of Participating Providers who have entered into a professional service agreement to provide quality health care services to Contractor's Enrollees and have been designated by the Enrollees as the Providers through whom the Enrollees will obtain health care benefits provided by Contractor under the state Medicaid program.

Provider - A Participating Provider or Subcontractor of Covered Services.

Quality Assurance (QA) - Process by which the degree of appropriateness and efficiency of health care services meet established professional standards; the degree to which actions taken or not taken maximize the probability of beneficial health.

Quarter - Unless otherwise specified, quarter means a calendar quarter of January through March, April through June, July through September, and October through December. July through September is the first quarter of the annual reporting year.

Risk - The possibility of monetary loss or gain by Contractor resulting from

service costs exceeding or being less than payments made to it by the Department.

Routine Care - Medical care for a condition that is not likely to substantially worsen in the absence of immediate medical intervention and is not Urgent Care or Emergency Care. Routine Care can be provided through regularly scheduled appointments without risk of permanent damage to the person's health status.

RHC – Rural Health Clinic.

Special Program - Service or benefit not required by the Contract, but which Contractor offers to Enrollees, per Section 5.5 of this attachment.

SSI – Supplemental Security Income.

Subcontract - Any written agreement between Contractor and another party to fulfill the requirements of this Contract.

Subcontractor - Party contracting with Contractor to perform services to fulfill the requirements of the Contract to which this is an attachment, or the requirement of any attachment to that contract.

Temporary Assistance for Needy Families (TANF) - A program that provides cash assistance and employment and training services for low income children and their parents. In effect July 1, 1997. See, Aid to Families with Dependent Children (AFDC).

Third Party - Any individual entity or program which is or may be legally liable to pay all or part of the expenditures for the Medicaid program furnished by Contractor through this Contract with the Department.

Third Party Liability Payment (TPL) – Payments received from individual entities or programs determined to be legally liable to pay of the expenditures for Medicaid under the Department’s Medicaid program.

Urgent Care - Medical care necessary for a condition that is not life threatening, but that requires treatment that cannot wait for Routine Care by a regularly scheduled clinical appointment because of the prospect of the condition worsening without timely medical intervention.

Utilization Review - Evaluation of the patterns or rates of use of health care services, procedures, and facilities.

SECTION II - FUNCTIONS AND DUTIES OF CONTRACTOR

2.1 Statutory Requirement

Contractor shall retain at all times during the term of this Contract a valid Certificate of Authority issued by the North Dakota Commissioner of Insurance.

2.2 Provision of Covered Services

(1) Contractor shall promptly provide or arrange to make available for Enrollees the provision of all services listed in Attachment L which are Medically Necessary and assume financial responsibility for the provision of those services. The Medicaid scope of services is the minimum scope of services permitted under this Contract. The state of North Dakota's Medicaid program is the governing provision of services and the definitive source for amount, scope, and duration of Covered Services. Contractor may offer Special Programs pursuant to Section 5.4 of this attachment.

(2) Contractor must require Providers to submit all claims no later than 12 months from the date of service. Contractor must pay 90 percent of all clean claims from practitioners within 30 Days of the date of receipt. Contractor must pay 99 percent of all clean claims from practitioners within 90 Days of the date of receipt. Contractor must pay all other claims, except claims for excluded or unauthorized services, within 12 months of the date of receipt.

(3) Changes in aid eligibility categories which become known subsequent to payment of a capitation payment shall not relieve Contractor of liability for provision of care for the period for which capitation payment has been made. If an Enrollee changes aid eligibility categories during a month the rate paid to Contractor will reflect the Enrollee's aid eligibility category as of the beginning of the month. If an Enrollee switches to a category that is not eligible for managed care the rate paid to Contractor will reflect the original aid eligibility category.

(4) Services must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service when based upon criteria such as

limits established in the Medicaid scope of service as identified in Attachment O; Medical Necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

(5) Contractor is required to provide high quality care for all services for which it contracts. These services must be Medically Necessary.

(6) Changes to the amount, duration, or scope of Covered Services mandated by federal or North Dakota law subsequent to the signing of this Contract will not affect the amount, duration, or scope of Covered Services for the term of this Contract, unless (1) agreed to by mutual consent, or (2) unless the change is necessary to continue to receive federal funds or due to action of a court of law.

(7) Contractor agrees to provide or pay for Medically Necessary second opinions, which include major diagnoses or Courses of Treatment. Contractor is responsible for determining Medical Necessity.

(8) Contractor shall not impose Enrollee copayments for Covered Services and Special Programs.

(9) Subcontracts for the provision of services beyond 50 miles from the borders of North Dakota may not be entered into if services of comparable cost and quality are available within the state of North Dakota.

(10) If Contractor is owned, controlled, or sponsored by or affiliated with a religious institution or religious organization, and provision of or arrangement for a Covered Service(s) would violate the institution or organization's religious or moral teachings and beliefs, Contractor must notify the Department in writing which Covered Service(s) it will not directly provide or arrange. Contractor is still financially responsible for those services. Per Section 2.16 of this attachment, Contractor must notify Enrollees of how to obtain the Covered Service(s).

(11) Contractor must include, at a minimum, in its definition of high risk pregnant women, those women whose fetus has a significant increased risk of death or serious impairment, either before or after birth, due to the mother's risk factors, including age extremes, adverse behavior, degree of literacy, physical or mental illness, depressed economic status, or previous prenatal history.

(12) Contractor must assure compliance with 42 CFR § Part 441, Subpart F, regarding sterilizations.

(13) Contractor must assure compliance with maternity and mental health requirements described in 42 U.S.C. § 1396u-2(b)(8).

(14) Contractor must provide female Enrollees with direct access to a women's health specialist within the Primary Care Network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist.

(15) If Contractor is unable to provide necessary medical services covered under the Contract to an Enrollee, these services must be adequately and timely covered out-of-Network for the Enrollee, for as long as Contractor is unable to provide them. Out-of-Network Providers must coordinate with Contractor with respect to payment. Cost to the Enrollee must be no greater than it would be if the services were furnished within the Primary Care Network.

(16) Contractor must participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

2.3. Noncovered Services

Services described in Attachment M are not Covered Services under this Contract.

2.4. Family Planning Service Access and Confidentiality

(1) Contractor shall give each Enrollee, including adolescents, the opportunity to use any Participating Provider or go to any family planning center for family planning services without requiring a referral. Contractor shall make a reasonable effort to Subcontract with all local family planning clinics and Providers, including those funded by Title X of the Public Health Services Act, and shall reimburse Providers for all family planning services regardless of whether they are rendered by a Participating Provider. At a minimum Contractor shall pay Providers of family planning services at the Medicaid rate. Contractor may require family planning Providers to submit claims or reports in specified formats before reimbursing services.

(2) Contractor shall keep family planning information and records confidential in favor of the individual patient.

(3) For purposes of self-referral, family planning services are covered and are defined as:

(a) Reproductive health exams;
(b) Patient counseling;
(c) Patient education;
(d) Lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol/triglycerides, prolactin, pregnancy tests, and diagnosis of infertility;
(e) Sterilizations as defined by Department rules;
(f) Screening, testing, and treatment of and pre and post test counseling for sexually transmitted diseases and HIV;
(g) Family planning medications and supplies provided by Title X clinics; and
(h) The diagnosis but not the treatment of infertility.

(4) Abortions are not a covered service or a family planning service for purposes of this Contract except as specifically permitted by North Dakota law.

(5) If a non-Participating Provider of family planning services detects a problem outside of the Covered Services the Provider shall refer the Enrollee back to Contractor.

2.5 Public Health Clinic Access

Contractor shall give each Enrollee, including adolescents, the opportunity to go to any public health clinic for immunizations and blood lead testing, but not well-child screens, without requiring a referral. Contractor shall also make a reasonable effort to Subcontract with all county public health clinics for these and other services. At a minimum, Contractor shall reimburse such public health clinics at the Medicaid rate. Any Health Tracks screenings performed will be paid by the Department directly to the performing public health clinic. Contractor may require public health clinics to submit claims or reports in specified formats.

2.6 Emergency Care

Contractor shall promptly provide or pay for Emergency Services and post-stabilization services, including Urgent Care and Emergency Room Screening services to determine if a medical emergency exists. Emergency Services must be available 24 hours per day, seven days per week.

(1) In emergency situations no preauthorization is required to provide necessary medical care and Enrollees may seek care from non-Participating Providers.

(2) Contractor may not retroactively deny a claim for an Emergency Room Screening examination because the condition, which appeared to be an Emergency Medical Condition under the definition, turned out to be non-emergency in nature.

(3) Contractor must pay for all Medically Necessary Emergency Services if an Enrollee is referred to the emergency room, even if the Enrollee's condition did not meet the Emergency Medical condition definition.

(4) Contractor may require Prior Authorization for any needed follow-up care.

(5) Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

(6) Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Network, or health plan of Enrollee's screening and treatment within 10 calendar Days of presentation for Emergency Services.

(7) An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(8) The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on Contractor.

(9) Post-stabilization Care Services are covered and paid for in accordance with the following provisions:

(a) Contractor is financially responsible for Post-stabilization Care Services obtained within or outside the Primary Care Network that are pre-approved by a plan Provider or Contractor representative.

(b) Contractor is financially responsible for Post-stabilization Care Services obtained within or outside the Primary Care Network, that are not pre-approved by a plan Provider or Contractor representative, but administered to maintain the Enrollee's stabilized condition within 1 hour of a request to Contractor for pre-approval of further Post-stabilization Care Services.

(c) Contractor is financially responsible for Post-stabilization Care Services obtained within or outside the Primary Care Network that

are not pre-approved by a plan Provider or Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if: (i) Contractor does not respond to a request for pre-approval within 1 hour; (ii) Contractor cannot be contacted; or (iii) a Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a plan physician is not available for consultation. If situation (iii) occurs, Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria is met in 42 CFR Section 422.113(c)(3) is met.

(d) Contractor must limit charges to Enrollees for Post-stabilization Care Services to an amount no greater than what Contractor would charge the Enrollee if he or she had obtained services through the Primary Care Network.

(e) Contractor's financial responsibility for Post-stabilization Care Services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the Enrollee's care; a plan physician assumes responsibility for the Enrollee's care through transfer; an organization representative and the treating physician reach an agreement concerning the Enrollee's care; or the Enrollee is discharged.

2.7 24-Hour Coverage

Qualified medical personnel must be accessible 24 hours each day, seven days a week, to provide direction to patients in need of urgent or Emergency Care. Such medical personnel include, but are not limited to, physicians, physicians on-call, licensed practical nurses, registered nurses or mid-level practitioners. Enrollees must have access to a live voice (employee of Contractor or a contracted Provider or an answering service) to handle medical problems during non-office hours and qualified medical personnel must respond to Enrollees within 60 minutes. This responsibility may be delegated to contracted Participating Providers but must be monitored by Contractor.

2.8 Health Tracks Program (EPSDT)

Contractor shall provide all Covered Services to eligible Health Tracks individuals enrolled with Contractor, including:

(1) Screening, diagnosis, treatment and referral for follow-up, with screens provided according to the periodicity schedule identified as required in

Attachment D;

(2) Maintenance of the Enrollee's consolidated health history, including information received from other providers;

(3) Physician's services as needed by the Enrollee for acute, episodic or chronic illness or conditions;

(4) Direct referral to a dentist to provide dental services (with "direct" meaning referral to a specific dentist, either the child's regular dentist or, if the child does not have a regular dentist, to a specific dentist) except dental referrals will be made by a Health Tracks coordinator for all screenings completed by a public health unit;

(5) Provision of assistance to the Enrollee in obtaining transportation;

(6) Assisting Enrollees in scheduling appointments for the above cited services, including either the actual scheduling of the appointments or giving adult caretakers the information necessary to schedule the appointment themselves;

(7) Other services as provided in Attachment D; and

(8) Immunizations.

In accordance with federal regulations, Contractor must provide or arrange for all Medically Necessary Covered Services found to be needed by a child as a result of a comprehensive screening visit or any other visit, whether or not they are ordinarily within the limits Contractor has placed on Covered Services for all Medicaid Enrollees. See Attachment D for a more detailed description and requirements of the Health Tracks program.

2.9 Comparability/Accessibility of Services

(1) Contractor shall provide Covered Services to Medicaid Enrollees under this Contract in the same manner as those services are provided to other Enrollees of Contractor, although delivery sites, Covered Services and Provider payment levels may vary. The Providers available to Medicaid Enrollees must be no less accessible in terms of travel time, handicapped accessibility, or proximity to public transportation routes than the Providers available to Medicaid fee-for-service Enrollees.

(2) Contractor must have procedures for the scheduling of appointments for Enrollees that are appropriate to the reason for the visit.

(a) An Enrollee needing Urgent Care must be seen within one Day of contacting the Participating Provider.

(b) Routine visits – 25% must be scheduled within 1 Day of making the appointment; 35% within 1 week of making the appointment; 10% within 2 weeks of making the appointment; and 30% within 4 weeks of making the appointment.

(c) Appointments must be scheduled by specific time intervals.

(3) The Enrollee survey, as required in Section 2.30 of this attachment, must be used to monitor timely access. Corrective action will be required if these standards are not met.

2.10 Enrollment Limits and Guarantees

(1) Contractor agrees that persons receiving benefits under Medicare (Title XVIII) or Medicaid (Title XIX) shall comprise no more than 75 percent of Contractor's total enrollment population, unless the Department obtains a federal waiver of this requirement. Before enrollment begins Contractor must report its total private enrollment level to the Department. This provision does not apply if Contractor is a grantee under Section 329 or 330 of the Public Health Service Act or is primarily owned and controlled by such grantees as provided pursuant to Section 903b(m)(2)(G) of the Social Security Act [42 U.S.C. § 1396(b)(m)(2)(G)] and 42 CFR § 434.26(b)(5).

(2) Prior to the start of the Contract the Department and Contractor will mutually agree in writing to establish a maximum Medicaid enrollment level for Medicaid Enrollees by Enrollment Area. Contractor must submit to the Department proposed enrollment levels by Enrollment Area and a description of the rationale for each enrollment level. Additionally, Contractor must have signed contracts with interested FQHCs and RHCs in the Enrollment Area or prove that the FQHC/RHC did not or could not meet the terms. If a new FQHC/RHC is available in the Enrollment Area after the contract is in effect, the Department will notify Contractor and Contractor will have 6 months from notification to Subcontract with or prove the FQHC/RHC did or could not meet the terms. Contractor must satisfy the Department of Contractor's ability to serve Enrollees in the Enrollment Area, prior to the initiation of enrollment. Subsequent to the establishment of this limit, if Contractor wishes to change its maximum enrollment level, Contractor must notify the Department 30 Days prior to the desired effective date of the change. If the change is an increase Contractor must demonstrate its capability to serve additional Enrollees. An increase will be

effective the first of the month after the Department confirms additional capacity exists. If the change is a decrease, and the existing enrollment would be larger than the new maximum enrollment, the Department will take one of the following actions:

(a) If capacity is decreased in order to comply with the federal rule that health plan enrollment cannot be composed of more than 75 percent Medicare and Medicaid Enrollees then the Department will disenroll the number of Enrollees necessary to comply with federal regulations.

(b) If capacity is decreased because of a reduction in the number of Participating Providers available to Medicaid Enrollees then the Department will give the patients of those Providers leaving the Primary Care Network the option to voluntarily disenroll from the plan.

(c) Enrollees already enrolled with Contractor must be given priority to continue that enrollment where Contractor does not have capacity to enroll all individuals seeking enrollment under the program.

2.11 Pre-existing Conditions

Contractor shall assume responsibility for all covered medical conditions inclusive of pre-existing conditions of each Enrollee as of the effective date of enrollment in the plan.

2.12 Hospitalization at the Time of Enrollment or Disenrollment

Inpatient hospital services provided during an entire inpatient hospital stay for an individual who enrolls in or disenrolls from Contractor's program while hospitalized will be paid by:

(1) The Department if a Medicaid Enrollee is admitted to an inpatient hospital prior to an effective enrollment date in Contractor's program and remains in the inpatient hospital setting on or after that effective enrollment date; and

(2) Contractor if a Medicaid Enrollee in Contractor's program is admitted to an inpatient hospital prior to an effective disenrollment date and the Enrollee remains in the inpatient hospital setting on or after the effective disenrollment date.

2.13 Coordination and Continuation of Care

Contractor shall have systems in place to ensure well managed patient care, including at a minimum:

(1) Management, coordination, and integration of health care through Participating Provider/gatekeeper/other means;

(2) Procedures to ensure that each Enrollee has an ongoing source of primary care appropriate to Enrollee's needs;

(3) Procedures to coordinate the services furnished to the Enrollee with services Enrollees receive from any other MCO and share the results of identification and assessment of any Enrollee with special health care needs to eliminate duplication with other MCOs serving the Enrollee;

(4) Implement procedures to ensure that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements described in Section 16 of the Contract;

(5) Systems to ensure provision of care in emergency situations, including an education process to help ensure that Enrollees know where and how to obtain Medically Necessary care in emergency situations;

(6) A system by which Enrollees may obtain a Covered Service or services that Contractor does not provide or for which Contractor does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which Contractor is owned, controlled, sponsored, or affiliated;

(7) Coordination and provision of Health Tracks services as described in Section 2.8 of this attachment; and

(8) Authorization of Services:

(a) Service authorization means the Enrollee's requests for the provision of a service.

(b) Written policies and procedures for processing requests for initial and continuing authorizations of services and referrals for Medically Necessary, specialty, secondary, and tertiary care.

(c) A mechanism to ensure consistent application of review criteria for authorization decisions, and consult with the requesting Provider when appropriate.

(d) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

(e) Notification to the requesting Provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider need not be in writing.

(f) Notification to the Enrollee in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.14 Health Education and Prevention

Contractor shall be encouraged to provide a continuous program of general health education or disease prevention and identification without additional cost to the Enrollee. Such a program may include publications, media presentations, and classroom instruction and must comply with applicable North Dakota laws. Programs of wellness education including stress management, smoking cessation, nutritional education, and physical fitness programs may be offered to Enrollees on a voluntary basis. These programs shall be conducted by qualified personnel.

Contractor must make Preventive Services available to Enrollees. Contractor shall periodically remind and encourage its Medicaid Enrollees to use benefits, including physical examinations and immunizations, which are available and designed to prevent illness.

Contractor must make a best effort attempt to perform an initial screening and assessment for all Enrollees within 90 Days from the date of enrollment. For any Enrollee the screening identifies as being pregnant or having special health care needs, a comprehensive health assessment should be performed no later than 30 Days from the date of identification. If a treatment plan for Enrollees with special health care needs is required based upon assessment, the treatment plan must be: (i) developed by the Enrollee's Primary Care Network with Enrollee participation, and in consultation with any specialists caring for the Enrollee; (ii) approved in a timely manner, if this approval is required; and (iii) in accordance with Quality Assurance and Utilization Review standards. Enrollees identified as having special health care needs must have direct access to a specialist as appropriate for the Enrollee's condition and identified needs.

2.15 Information Requirements

Contractor must provide all enrollment notices, informational materials, and instructional materials relating to Enrollees and Potential Enrollees in a manner and format that may be easily understood and a mechanism to help Enrollees and Potential Enrollees understand the requirements and benefits of the plan. Contractor must also comply with the following:

(1) Make written information available in the prevalent non-English languages, as identified by the Department, in its particular service area.

(2) Make oral interpretation services available free of charge to Enrollees and Potential Enrollees.

(3) Notify Enrollees that oral interpretation services are available for any language and written information is available in prevalent languages and how to access those services.

(4) Create written materials in an easily understood language and format.

(5) Make written materials available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(6) Inform all Enrollees and Potential Enrollees that information is available in alternative formats and how to access those formats.

(7) Provide written notice of any significant change, to each Enrollee at least 30 Days before the intended effective date of the change.

(8) Provide information on the informal and formal grievance procedures as described in Section 17 of this Contract.

(9) Provide information on the policies and the processes for requesting and filing of a grievance, Department review, and fair hearing as described in Section 17 of this Contract.

(10) Provide advance Directives.

(11) Provide additional information upon request, including information on the structure and operation of Contractor and/or Physician Incentive Plans.

2.16 Enrollee Handbook and Membership Card

Upon request, Contractor shall provide a Medicaid-specific Enrollee handbook, to Potential Enrollees and to the Enrollee household within one week of initial enrollment notification to Contractor, which at a minimum, shall include:

(1) The 24-hour per-day phone number which can be used for assistance in obtaining Emergency Care or for Prior Authorization;

(2) Information on Covered Services offered by Contractor;

(3) Lists of local Participating Providers and location of facilities and information on how to choose a Participating Provider. The list should include names, locations, telephone numbers of, and non-English languages spoken by current contracted Providers in the service area, including identification of Providers that are not accepting new patients;

(4) Hours of service availability;

(5) Informal and formal grievance procedures as described in Section 17 of this Contract;

(6) Voluntary and special disenrollment policies;

(7) Health Tracks policies;

(8) Family planning policies;

(9) Policies on the use of emergency and Urgent Care facilities;

(10) Limited Contractor liability for services from non-Participating Providers, i.e., only Emergency Care, family planning services, and certain public health Clinic Services and referrals can be obtained from non-Participating Providers;

(11) Education regarding the appropriate use of health care services in a managed care system;

(12) A written description of treatment policies and any restrictions or limitations on services;

(13) Policies on the processes for requesting filing of a grievance, Department review and fair hearing as described in Section 17 of this Contract;

(14) Rights and responsibilities of Enrollees;

(15) Contractor's policy on referrals for specialty care; and

(16) Procedures for changing practitioners.

Contractor must update and maintain the handbook as needed explaining changes in the above policies.

The Department must review and approve all Enrollee handbooks. The Department will review the handbooks and approve or disapprove them within 30 Days. However, problems and errors subsequently identified by the Department must be corrected by Contractor. Non-substantive mistakes in written material must be corrected at the time of the next printing.

Enrollee handbooks shall be made available in languages other than English if, in the Department's determination, a significant number of Enrollees are conversant only in those other languages. In addition, such handbook shall be prepared in a manner which is clear and understandable to an individual who has completed no more than the eighth grade.

Standard explanatory language on Health Tracks (EPSDT), family planning and public health Clinic Services, grievance and appeal rights, and emergency and Urgent Care shall appear in all handbooks and is included in Attachment E. Any exceptions to the standard language must be approved in advance by the Department.

Standard explanatory language may change during the course of the Contract period. If changes are required by federal or North Dakota law, the new standard explanatory language must be inserted into the Enrollee handbooks.

Any membership card produced by Contractor for Medicaid Enrollees must state that Enrollees have zero copayments and must state the phone number that should be called to access coverage 24-hours per day.

2.17 Information Upon Request

Upon request, Contractor shall provide an Enrollee or Potential Enrollee any of the following information:

(1) Contractor’s and health care facilities’ licensure, certification, and accreditation status.

(2) Information that includes, but is not limited to, education, licensure, and Board certification and recertification of health care professionals.

(3) Information for accessing services, including factors such as physical accessibility and non-English languages spoken.

(4) A description of the procedures Contractor uses to control utilization of services and expenditures.

(5) A summary description of the methods of compensation for physicians.

(6) Information on the financial condition of Contractor, including the most recently audited information.

(7) Any information given to Enrollees or Potential Enrollees.

2.18 Conversion Privileges

Contractor must offer conversion to a private pay policy if enrollment stops because Medicaid eligibility is lost, subject to the provisions of N.D.C.C. Ch. 26.1-18.1.

2.19 Choice of Health Professional

Contractor must inform each Enrollee about the full panel of Participating Providers. To the extent possible and appropriate, Contractor must offer each Enrollee covered under this Contract the opportunity to choose a clinic location within the Primary Care Network at the time of enrollment. This does not preclude Contractor from assigning a Primary Care Network clinic location to an Enrollee who does not choose one. Contractor may assign an Enrollee to a Primary Care Network clinic location when an Enrollee fails to chose one after being notified to do so. The assignment must be appropriate to the Enrollee's age, sex, and residence. Contractor may limit an Enrollee's ability to change a Primary Care Network clinic location without cause. A good faith effort must be made to give written notice of termination of a contracted Primary Care Network clinic location, within 15 Days after receipt or issuance of the termination notice, to each Enrollee who received his or her primary care from, or was seen on a regular basis at, the terminated Primary Care Network clinic location.

2.20 Quality Assurance (QA)

(1) Contractor shall comply with 42 CFR § 434.34 which requires Contractor to have a Quality Assurance system approved by the Department which:

(a) Is consistent with the utilization control requirements of 42 CFR § 456;

(b) Provides for review by appropriate health professionals of the process followed in providing health services;

(c) Provides for systematic data collection of performance and participant results;

(d) Provides for interpretation of these data to the practitioners;

(e) Provides for making needed changes;

(f) Detects both underutilization and overutilization of services; and

(g) Assesses the quality and appropriateness of care furnished to Enrollees with special health care needs.

(2) Annually measure and report to the Department its performance, using standard measures required by the Department, or data specified by the state of North Dakota that enables the Department to measure the performance; or a combination of the activities listed above.

(3) Maintain and operate a Quality Assurance system which includes at least the following elements:

(a) A Quality Assurance plan.

(b) A person who is responsible for the operation and success of the QA system. This person shall have adequate experience for successful QA, and shall be accountable for QA oversight of all Contractor's own Providers, as well as Contractor's Subcontractors.

(c) The QA director shall spend an adequate percentage of time on QA activities to ensure that a successful QA system will exist. The QA system shall have access on an as-needed basis to a variety of health professions and shall be directed by a QA committee which includes representation from a variety of medical disciplines and Contractor's Board of Directors.

(d) The QA committee shall be in an organizational location within Contractor such that it can be responsible for all aspects of the QA system.

(e) QA activities shall be sufficiently separate from Utilization Review activities, so that QA activities can be distinctly identified as such.

(f) The QA activities of Participating Providers and Subcontractors, if

separate from Contractor QA activities, shall be integrated into the overall QA system, and Contractor shall provide feedback to the Providers and Subcontractors regarding the operation of any such independent QA effort.

(g) QA activities shall be reported in writing monthly to the QA committee, Contractor's Board of Directors, and the Department.

(h) The QA committee shall meet at least Quarterly, produce written documentation of QA and QA committee activities, and make recommendations for improvement in the quality of care and services provided Enrollees.

(i) Contractor shall have a written procedure for reviewing the results of implementation of recommendations of the QA committee. Reviews shall be reported Quarterly to the QA committee, Contractor's Board of Directors, and the Department.

(j) The Department may confirm compliance with this requirement through on-site visits.

Contractor must conduct performance improvement projects that can be expected to have a favorable effect on health outcomes and Enrollee satisfaction. Performance improvement projects are Contractor initiatives that represent the entire Medicaid Enrollee population, focus on clinical and non-clinical areas, and that involve the following:

(1) Measurement of performance using objective quality indicators.

(2) Implementation of system interventions to achieve improvement in quality.

(3) Evaluation of the effectiveness of the interventions.

(4) Planning and initiation of activities for increasing or sustaining improvement.

Contractor must initiate each year one or more projects among the required clinical and non-clinical areas.

Clinical areas include:

(1) Prevention and care of acute and chronic conditions;

(2) High-volume services;

(3) High-risk services; and

(4) Continuity and coordination of care.

Non-clinical areas include:

(1) Grievances and appeals;

(2) Access to, and availability of, services; and

(3) Cultural competence.

In addition to requiring Contractor to initiate its own performance improvement projects, the Department may require that Contractor conduct particular performance improvement projects on a topic specified by the Department and participate Annually in at least one statewide performance improvement project.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care each year.

The Department will review, at least Annually, the impact and effectiveness of Contractor's quality assessment and performance improvement.

Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

The health information system must collect data on Enrollee and Provider characteristics and on services furnished to Enrollees though an Encounter Data system as specified in Section IV of this attachment and Attachment K of this Contract.

The health information system must ensure that data received from Providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate.

All collected data must be made available to the Department and upon request to CMS.

Contractor must adopt practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the Enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

Decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Contractor must distribute the guidelines to all affected Providers and upon request, to Enrollees and Potential Enrollees.

2.21 Utilization Reviews

Contractor must provide for a measurement of the services provided to Enrollees which quantifies those services in order to identify suboptimal service areas and trends. Quarterly written reviews will be made available to the appropriate practitioners and the Department. Compensation to individuals or entities that conduct utilization management activities may not be structured so as to provide incentives for the individual or Contractor to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

2.22 Medical Records

Contractor must establish and maintain a confidential, centralized medical record for each Enrollee that details care received. The medical record should demonstrate coordination of patient care; for example, relevant medical information from referral sources must be reviewed and entered into Enrollees' medical records. This medical record may be kept at an Enrollee's chosen Primary Care Network clinic location.

Contractor must also compile and maintain in a centralized data base encounter-level data on the services rendered to Medicaid Enrollees and must submit this information to the Department as specified in Attachment K.

2.23 Participating Providers

When establishing and maintaining the Provider Primary Care Network, Contractor must consider:

(1) The anticipated Medicaid enrollment and expected utilization of services.

(2) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the contracted Medicaid services.

(3) The numbers of Primary Care Network Providers who are not accepting new Medicaid patients.

(4) The geographic location of Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Medicaid Enrollees with disabilities.

Contractor must establish written policies and procedures for enrollment, retention, and reimbursement criteria for Participating Providers, subject to the credentialing requirements in Section 2.24 of this attachment, except as noted below and in Sections 2.4, 2.5, and 2.6 of this attachment.

Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification for any Provider acting within the scope of that Provider's license or certification under applicable North Dakota law solely on the basis of the Provider's license or certification. Contractor shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. This does not restrict Contractor: (i) to contract with Providers beyond the number necessary to meet the needs of its Enrollees; (ii) from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees. Contractor must limit participation in this Medicaid program to Providers who accept, as payment in full, the amounts paid by Contractor. If Contractor declines to include individual or groups of providers in its Primary Care Network, it must give the affected Providers written notice of the reason for its decision.

Contractor shall ensure that high-risk pregnant women receive adequate prenatal and preventive care in order to reduce the chance of unhealthy birth outcomes for newborns. Contractor may use a primary care physician or other means including a separate case manager to meet this requirement.

Contractor shall offer federally qualified health centers (FQHCs) or rural health clinics (RHCs) which serve Enrollees in the Enrollment Area terms and conditions, excluding reimbursement, at least as favorable as those offered to other Providers, providing the FQHC or RHC substantially meets the same access and credentialing criteria as Contractor's other Providers, as specified in Sections 2.9 and 2.24 respectively. At a minimum, Contractor must pay an FQHC or RHC Participating Provider either the Medicaid Interim Rate for each Medically Necessary Enrollee visit to the FQHC or RHC or make the same capitation payment per Enrollee offered to Contractor's other Providers. The Department may not delegate cost based reimbursement to Contractor. The Department is responsible for paying the shortfall to the FQHC or RHC or recouping the excess from the FQHC or RHC for the difference between the amount paid by Contractor and the reasonable cost to the FQHC or the

RHC to provide the Covered Service.

Contractor is not responsible for disproportionate share payments to hospitals. The Department will make disproportionate share payments for Enrollee admissions directly to such facilities.

All laboratory testing sites providing services under this Contract must be either a CLIA certified laboratory or have a waiver of a certificate of registration along with a CLIA identification number.

2.24 Credentialing and Recredentialing

(1) Contractor shall establish and verify minimum credentialing and recredentialing criteria for all professional Participating Providers including:

(a) Appropriate license or certification as required by law;

(b) Verification that Providers have not been suspended or terminated from Medicare or Medicaid in any state;

(c) Verification that Providers of Covered Services meet minimum requirements for Medicaid participation;

(d) Evidence of malpractice and liability insurance or coverage under the Federal Tort Claims Act;

(e) Encouragement of board certification or eligibility, as appropriate; and

(f) A current statement from the Provider addressing:

X Lack of impairment due to chemical dependency or drug abuse;
X Physical and mental health status;
X History of past or pending professional disciplinary actions, sanctions, or licensure limitations;
X Revocation and suspension of hospital privileges; and
X History of malpractice claims;

(g) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association, or any appropriate professional organization;

(h) A National Provider Identifier in accordance with HCFA

implementation.

(2) For the purposes of credentialing and recredentialing, Contractor must perform a check on all Participating Providers by contacting the National Practitioner Data Bank (NPDB). The Department will notify Contractor immediately if a Provider Subcontracted by Contractor is subsequently terminated or suspended from participation in the Medicare or Medicaid programs. Upon such notification from the Department or any other source, Contractor must immediately act to terminate the Provider from participation. The Department will recoup from Contractor any payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by Contractor in a manner that is not consistent with the Provider's licensure.

(3) Additional credentialing and recredentialing criteria for Providers must include:

(a) Ability to perform or directly supervise the ambulatory primary care services of Enrollees;

(b) Membership of the medical staff with admitting privileges to at least one accredited general hospital or medical assistance facility or an acceptable arrangement with a Participating Provider with admitting privileges; and

(c) A valid Drug Enforcement Agency (DEA) certification.

(4) County public health clinics and family planning Providers to which patients refer themselves, per the requirements of Sections 2.4 and 2.5 of this attachment, do not require credentialing.

2.25 Coordination with Providers of Noncovered Services

Contractor must follow established Medicaid procedures and provide referrals and assistance in scheduling appointments to Enrollees in need of Medicaid Covered Services outside of the scope of this Contract as described in Attachment M. These services include vision care, dental care, and those Health Tracks services which are not described in Attachment M.

Contractor must also comply with all policies developed by the Department for linking the services provided by Contractor to those non-Covered Services described in Attachment M. Contractor is encouraged to seek cooperation with Community-based Organizations.

2.26 Advance Directives

Contractor must comply with 42 CFR § 489 and N.D.C.C. Chapters 23-06.4 and 23-06.5 relating to written policies and procedures respecting advance directives. This requirement includes provisions to inform and distribute written information to adult individuals concerning policies on advance directives upon enrollment.

2.27 Quality Reviews

Contractor must make every effort to comply with external quality reviews that may be implemented by the Department or organization contracted by the Department for Annual periodic medical audits. This may include participating in the design of the external review, collecting data, and making data available to the review organization. External quality reviews must include at least a review of the quality outcomes, timeliness of, and access to, the services covered under this Contract.

2.28 Notification of Medicare and TPL Eligibility

Medicare and Medicaid dual eligibles will not be eligible to join Contractor's plan during this Contract term. Contractor shall contact the Department's Division of Medical Services if it becomes aware that an Enrollee has become eligible for Medicare while on Medicaid. It shall also notify the Department's Division of Medical Services if it becomes aware of insurance coverage which differs from the health coverage information forwarded to Contractor by the Department via Contractor enrollment notification file.

2.29 Training Department Staff

Contractor shall participate in educational sessions, at the request of the Department, to update staff of county social service boards and the Department regarding information which would assist staff or prospective Enrollees in evaluating Contractor's plan or Contractor's performances.

2.30 Enrollee Surveys

Contractor shall survey all Enrollees at least once each year to determine the level of enrollee satisfaction. Contractor shall report the results of those surveys to the Department. Survey results must distinguish, by demographic category, between Enrollees provided services under this Contract with the Department and other Enrollees.

2.31 Fraud and Abuse

Contractor shall submit to the Department a Quarterly report of suspected fraud and abuse that includes:

(1) The number of suspected fraud and abuse cases; and

(2) For each case of suspected Provider fraud and abuse the:

(a) Provider's name and ID number;
(b) Source of the complaint;
(c) Type of Provider;
(d) Specifics of the complaint;
(e) Approximate cost of services or procedures; and
(f) Legal and Administrative decision of the case.

Contractor must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. These arrangements or procedures must include the following:

(1) Written policies, procedures, and standards of conduct that articulate the commitment to comply with all applicable federal and state of North Dakota standards.

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.

(3) Effective training and education for the compliance officer and the employees.

(4) Effective lines of communication between the compliance officer and the employees.

(5) Enforcement of standards through well-publicized disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contract.

2.32 Enrollee Rights

The Enrollee is free to exercise his or her Enrollee rights without adversely affecting the way Contractor treats the Enrollee. The Enrollee has the right to:

(1) Receive information in accordance with Sections 2.15 and 2.16 of this attachment.

(2) Be treated with respect and with due consideration for his or her dignity and privacy.

(3) Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.

(4) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(6) Request and receive a copy of his or her medical records, and to request that they be amended or corrected as specified in 45 CFR Sections 164.524 and 164.526.

Contractor has written policies regarding the Enrollee rights specified in this section and must comply with any applicable federal and state laws of North Dakota that pertain to Enrollee rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Enrollees.

2.33 Provider – Enrollee Communication

Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf on an Enrollee who is his or her patient:

(1) For the Enrollees health status, medical care, or treatment options, including any alternative treatment options that may be self–administered.

(2) For any information the Enrollee needs in order to decide among all relevant treatment options.

(3) For the risks, benefits, and consequences of treatment or non-treatment.

(4) For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Although Contractor is required under the preceding paragraphs of this Section to provide, reimburse for, or provide coverage of, a counseling or referral service, Contractor is not required to do so if Contractor objects to the service on moral or religious grounds. Contractor must furnish information about the services it does not cover as follows:

(1) To the Department: (i) with its application for a Medicaid Contract; and (ii) whenever it adopts the policy during the term of the Contact; and

(2) Consistent with provisions of 42 CFR 438.10: (i) to Potential Enrollees before and during enrollment ; and (ii) to Enrollees 90 Days after adopting the policy with respect to any particular service.

Contractor shall comply with any North Dakota or federal statute, rule, or regulation intended to limit or prevent restriction on, or interference with, communications between a health care Provider and an Enrollee concerning Medically Necessary treatment options.

Any violation prohibiting Provider-Enrollee communication is subject to sanction.

2.34 Liability for Payment

Contractor shall not hold Enrollees liable for any of the following:

(1) Covered Services provided to the Enrollee, for which Contractor does not receive capitation payment; or covered services Contractor does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.

(2) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if Contractor provided the services directly.

(3) Contractor debts, in the event of insolvency.

(4) Covered Services provided to the Enrollee, for which the Department does not pay Contractor.

SECTION III - FUNCTIONS AND DUTIES OF THE DEPARTMENT

3.1 Eligibility Determination

The Department shall on a monthly basis identify individuals and categories of individuals who are eligible for Contractor enrollment and notify the individuals of their eligibility for Contractor enrollment. Medicaid eligibility groups eligible for Contractor enrollment are identified in Attachment F.

3.2 Contractor Enrollment Information

For each month of coverage throughout the term of the Contract, the Department shall transmit the Contractor enrollment notification file to Contractor. Contractor enrollment information will provide Contractor with identifying information about its Medicaid Enrollees, and will be created electronically after month end cut off. Specifications for the Contractor enrollment notification file are described in Attachment H.

3.3 Utilization Control

The Department shall waive, to the extent allowed by law, any current Department requirements for Prior Authorization, second opinions, copayment, or other Medicaid restrictions for the provision of Covered Services provided by Contractor to Enrollees.

3.4 Enrollee Surveys

The Department shall conduct Enrollee surveys, at its own discretion.

3.5 Enrollment, Disenrollment

The Department shall process enrollments and disenrollments and offer eligible individuals a choice of managed care plans. If the Department obtains a federal waiver, the Department may mandatorily assign newborns born to a mother who is an Enrollee or a Potential Enrollee who fails to choose a managed care program to Contractor. When mandatorily assigning a Potential Enrollee to Contractor, the Department shall not exceed the maximum enrollment level per Section 2.10 of this attachment.

The Department shall present Contractor's plan in an unbiased manner to eligible individuals in Contractor's Enrollment Area. Such presentation shall ensure that eligible individuals are informed prior to initial enrollment about the nature of requirements of participating with Contractors, Special Programs Contractor offers, identification of Primary Care Network Providers, and the right to terminate enrollment voluntarily at any time, unless otherwise provided by federal law or waiver.

The Department shall develop general materials to assist eligible individuals in choosing a managed care plan.

3.6 Drug Utilization Reports

On a monthly basis the Department will provide data concerning drug use by Enrollees, to Contractor, in the manner required by Attachment I.

SECTION IV - REPORTS AND DATA

4.1 Periodic Reports

Contractor agrees to furnish information from its records to the Department and the Department's authorized agents which the Department may require to administer this contract including:

(1) Quarterly reports to the Department summarizing formal and informal grievances and resolutions. These reports should be in the format and contain the information required by N.D.C.C. Ch. 26.1-18.1.

(2) Summaries of amounts recovered from third-party payers for services provided Enrollees under this Contract to be submitted Quarterly. See, Attachment K for the report format.

(3) Service Encounter Data for Enrollees under this Contract to be submitted electronically and monthly in the format required in Attachment K. Data must be sufficient to identify the Provider delivering the services.

(4) Copies of reports submitted to the North Dakota Commissioner of Insurance or a signed statement that these reports may be shared with the Department. The Department will keep this information confidential to the extent permitted by open records laws and exceptions.

(5) Other reports specified in Attachment K.

Reports will be due 90 Days after expiration of the period on which the report is based. Information shall be based on date of service. Quarterly reports shall be due for the first full Quarter. Reports due Annually shall cover the Department Fiscal Year. If Contractor starts enrolling eligible individuals in a month other than July, the initial annual reports shall cover full Quarter(s) and become annual as of July. The Department reserves the right to require additional reports in future Contract years.

4.2 Special Reporting and Compliance Requirements

Contractor shall comply with the following federal reporting and compliance requirements for the services listed below, and shall submit applicable reports to the Department in the format required in Attachment J. The Department may request interim reports if needed for a federal audit.

(1) Hysterectomies and sterilizations shall comply with 42 CFR § 441, Subpart F -- Sterilizations. This includes completion of the consent form in Attachment J.

(2) Health Tracks services and reporting for screenings completed by Providers who are paid directly by Contractor shall comply with 42 CFR § 441 Subpart B -- Early and Periodic Screening, Diagnosis, and Treatment.

(3) Contractor shall complete and submit HCFA Form 1513, "Disclosure of Ownership and Control Interest Statement" prior to the start of the Contract.

4.3 Disclosure of Interlocking Relationships

If Contractor is contracting with the Department to provide services to Medicaid Enrollees on a capitated or risk basis and is not also a federally qualified MCO under the Public Health Service Act, Contractor must report to the Department, and on request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General, a description of transactions between Contractor and parties in interest as defined in 42 U.S.C.A. § 300e-17(b)(1991). Transactions that must be reported include: (i) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services or facilities (but not salaries paid to employees); and (iii) any loans or extensions of credit. Contractor shall make the information reported available to its Enrollees upon reasonable request.

4.4 Department's Data Files

The Department's data files and data contained therein shall be and remain the Department's property and shall be returned to the Department by Contractor upon the termination of this Contract at the Department's request, except that any Department data files no longer required by Contractor to render services under this Contract shall be returned upon such determination at the Department's request.

The Department's data shall not be used by Contractor for any purpose other than that of providing services to the Department under this Contract, nor shall the Department's data or any part thereof be disclosed, sold, assigned, leased or otherwise disposed of to third parties by Contractor unless there has been prior written Department approval.

The Department shall have the right of access and use of any data files retained or created by Contractor for systems operation under this Contract.

4.5 Safeguarding the Department's Data

Contractor shall establish and maintain at all times reasonable safeguards against the destruction, loss or alteration of the Department's data and any other data in the possession of Contractor necessary to the performance of operations under this Contract.

SECTION V - ENROLLMENT AND DISENROLLMENT

5.1 Enrollment

Enrollment in Contractor's plan shall be voluntary. Contractor shall accept as enrolled all persons who appear as Enrollees on Contractor enrollment notification file, provided that the number of Enrollees does not exceed the ceiling as referenced in Section 2.10 of Attachment C of this agreement.

If a request for enrollment is filed with Contractor, Contractor shall forward the request to the appropriate County Social Service Board for the service area within 5 working days.

Contractor shall conduct a continuous open enrollment period during which Contractor shall accept all eligible individuals in the order in which they apply without regard to health status of the individual or any other factor(s) up to the limits described in Section 2.10 of Attachment C of this agreement.

The effective enrollment date is the first day of the month following the month in which the person elected enrollment with Contractor.

Contractor and Subcontractors will not discriminate against individuals eligible to enroll on the basis or race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

5.2 Voluntary Disenrollment

All Enrollees shall have the right to request termination or disenrollment from Contractor at any time without cause. Contractor must inform each Enrollee of that right at the time of enrollment. A voluntary disenrollment is effective the first Day of the second month after the month in which the Enrollee's request is received and processed. Contractor shall forward to the appropriate administering County Social Service Board all oral or written disenrollment requests from Enrollees within 5 working days.

5.3 Special Disenrollment

Contractor may request in writing and the Department may approve disenrollment or exemption from enrollment for specific cases or persons where there is good cause. Good cause includes, but is not limited to, a case in which an Enrollee:

(1) Has committed acts of physical or verbal abuse that pose a threat to

Providers or other Enrollees of Contractor;

(2) Has allowed a non-Enrollee to use Contractor-issued certification card to obtain services;

(3) Has moved outside the Enrollment Area;

(4) Has violated rules of Contractor stated in the evidence of coverage or Enrollee handbook;

(5) Has repeatedly violated rules adopted by the North Dakota Commissioner of Insurance for enrollment in an MCO; or

(6) Is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the Enrollee's care. Disenrollment of an Enrollee for this reason is only permitted if Contractor can demonstrate that it provided the Enrollee with the opportunity to select an alternative Primary Care Network clinic location, made a reasonable effort to assist the Enrollee in establishing a satisfactory Provider-patient relationship, and informed the Enrollee that the Enrollee may file a grievance on this matter.

Extensive or expensive Enrollee health care needs shall not necessarily constitute good cause.

5.4 Special Programs and Additional Services

Contractor may provide Special Programs upon approval by the Department. Such approval shall be by amendment of this Contract. Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to Enrollees except for Special Programs.

5.5 Nondiscrimination

Contractor shall not discriminate in enrollment activities on the basis of health status or the Enrollee’s need for health care services, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs Contractor’s ability to furnish services to either this particular Enrollee or other Enrollees), and shall not attempt to discourage or delay enrollment with Contractor of eligible Medicaid Enrollees.

ATTACHMENT D: MCO/HEALTH TRACKS POLICIES AND PROCEDURES

1. Background

Federal law and regulations governing the administration of the Medicaid program require that a state provide health screenings and necessary diagnostic and treatment services for all Children under age twenty-one who are eligible for Medicaid. Contractor will coordinate Health Tracks screenings with the local public health units. The Department will pay the public health units directly for screening services.

2. Screening, Diagnosis, and Treatment

Screenings are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, Children, and youth to identify individuals who have, or have a risk of having, a health condition or problem. Contractor must require these assessments to follow either the American Association of Pediatrics guidelines or the Bright Futures periodicity schedule and must be consistent with 42 CFR § 441.56. Contractor shall inform the Department of the selected periodicity schedule within 30 Days of any change in the selection of a periodicity schedule.

These periodic screenings must include:

A. A medical screening which includes:

(1) Comprehensive health and developmental history including assessment of physical, mental, and emotional development and nutritional health;

(2) Comprehensive unclothed physical examination;

(3) Appropriate immunizations according to age and health history;

(4) Laboratory tests including lead blood level assessment appropriate for age and risk factors and consistent with protocols described in Section 3 of this attachment; and

(5) Health education including anticipatory guidance concerning disease and accident prevention;

B. Appropriate vision testing and necessary follow-up care;

C. Appropriate hearing testing and necessary follow-up care; and

D. Appropriate dental screening services and necessary follow-up care.

Any Medically Necessary treatment, whether a Covered Service for adults in the Medicaid program or not, must be provided under the Health Tracks program.

Contractor will maintain each child's consolidated health history including information received from other providers and will provide physicians' services as needed for acute, episodic, or chronic illnesses or conditions.

3. Blood Lead Level Screening Protocols/Lead Poisoning Questionnaire

A. Ages screened.

(1) All children age 6 to 72 months are considered at risk for lead toxicity and must be screened by a blood lead test for lead poisoning.

(2) All children age 6 to 26 months will be screened by a blood lead test for lead blood level. A lead screening questionnaire will be conducted for all children age 6 to 72 months. If there is a positive response to any question or if a parent or guardian is not sure of an answer to any question a blood lead test will be done.

(3) Lead screening by a questionnaire will be conducted at least annually consistent with the child's age.

(4) Elevated blood levels of lead (10 m/ml or higher) will be managed by the Contractor and follow-up will use Center for Disease Control protocols.

B. The following questions are to be answered by a parent or guardian of each Health Tracks eligible child 6 to 72 months of age at each periodic health assessment at least annually.

(1) Does your child live in or regularly visit a house or other location with peeling or chipping paint which was built before 1960? May include a day care center, preschool, school, barn, home of babysitter, relative, friend, etc.

_____ Yes _____ No _____ Don't Know

(2) Does your child live in or regularly visit a house built before 1960 with recent or ongoing renovation or remodeling?

_____ Yes _____ No _____ Don't Know

(3) Does your child have a parent, brother, sister, housemate or playmate who is being treated or followed for lead poisoning, e.g. blood lead level > 10 g/dL?

_____ Yes _____ No _____ Don't Know

(4) Does your child live with someone whose job or hobby involves exposure to lead, e.g. painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair?

_____ Yes _____ No _____ Don't Know

(5) Does your child live near an active lead smelter or battery recycling plant or other industry likely to release lead?

_____ Yes _____ No _____ Don't Know

4. Other Services

Contractor shall provide additional services for Health Tracks Children including:

A. Informing families of the program at the time of enrollment and annually thereafter;

B. Notifying families when screening services are due;

C. Offering assistance in obtaining Health Tracks screening services (such as setting up appointments);

D. Arranging for necessary transportation; and

E. In a case management process, assisting in arranging follow-up care if the child requires diagnosis and treatment.

5. Reporting

Contractor shall report Health Tracks screenings and services as required in Attachment K.

ATTACHMENT E: STANDARD ENROLLEE HANDBOOK LANGUAGE

The following standard language must be included in Medicaid Enrollees' member handbooks unless alternate language is approved by the Department. This language is not intended to be comprehensive: It should simply supplement the information included in Contractor's commercial Enrollee handbook. In addition, please note that all of the requirements of Section 2.16 of Attachment C regarding the Enrollee handbook must be met. The language below does not include all of the requirements of Section 2.16 of Attachment C. This standard language is written at the eighth grade level.

Complaints

[Insert Contractor's internal complaint, grievance, and appeal policies here.]

If you are not satisfied with [Contractor's name] written decision about your appeal, you may appeal the decision. Write your complaint and mail it to the address below. You must do this within 15 Days of receiving a letter about [Contractor's name] decision.

Appeals Supervisor
Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0250

Services

As a member of [Contractor's name] you are entitled to all covered Medicaid services. You will receive most of these Covered Services through [Contractor's name]. These Covered Services include:

- X Primary doctor care
- X Pregnancy and new baby care
- X Birth control and family planning services
- X Specialist doctor care
- X Surgery
- X Lab and x-ray services
- X Medical supplies
- X Podiatry (foot care) services
- X Chiropractic medicine care
- X Inpatient and outpatient hospital care
- X Emergency care
- X Home health care and hospice care
- X Nutrition services

X Physical therapy, occupational therapy, and speech therapy services
X Mental health services
X Transportation services including ambulance
X Hearing aids and hearing testing services
X Kidney dialysis Clinic Services
X Federally qualified health Clinic Services
X Rural health Clinic Services

If a service you need is not listed here call [Contractor's name] at [phone number]. Call before receiving the service. Special features of some of the benefits are explained below.

Birth Control and Family Planning Services

Birth control, pregnancy testing, and reproductive health services are available to all Enrollees. They are confidential. You can receive these services from your Primary Care Network or from any family planning Provider. In _____ County, these Providers include [clinic names] available by phone at [phone number]. You can ask for help in choosing a family planning Provider. Call [Contractor's name] at [phone number] for help.

Immunizations

Immunizations are available to all Enrollees. You can receive these services from your Primary Care Network or from any county public health clinic. In _____ County, these Providers include [clinic names] available by phone. You can ask for help in choosing a Provider for these services. Call [Contractor's name] at [phone number] for help.

Transportation

Transportation for medical care may be available if no other source is available. This includes travel to and from medical services. Call [Contractor's name] at [phone number] for more information.

Necessary transportation by ambulance is paid for by [Contractor's name].

Health Tracks

Health Tracks is a special health program for Children which provides regular health checkups. Health Tracks provides care for any health problems that are found during a health checkup.

Routine Health Tracks checkups are a good way to keep your child healthy. These checkups can detect childhood health problems early and treat them before they become serious. Health Tracks checkups can also help parents know about free child health services available to Medicaid Enrollees.

Health Tracks services include periodic physical exams; hearing and vision tests; blood, lead poisoning, and urine lab tests; and immunizations to protect your child from illness. Children will also be given help in choosing a dentist for preventive dental care. Transportation assistance to and from Health Tracks appointments may be requested. Call [Contractor's name] at [phone number] for more information.

Emergency Care and Urgent Care

[Contractor's name] will pay for all covered medically necessary care you get from [Contractor's name] health care Providers. [Contractor's name] will also pay for Emergency Care and Urgent Care if you follow the rules below.

Emergency Care

Emergency Care is a medical condition which most non-medical people think is life-threatening or could cause death or severe, permanent damage or injury to a person or unborn baby if not treated immediately. If you need Emergency Care go to the nearest doctor or hospital. Examples of emergencies are:

Severe difficulty in breathing	Suspected heart attack
Unconsciousness	Severe burns
Severe or unusual bleeding	Poisoning

You must notify [Contractor's name] as soon as possible that you are receiving Emergency Care. If you do not notify [Contractor's name] you may have to pay for your care.

Urgent Care

Urgent Care is medical care necessary for a non-life threatening condition that cannot wait for a regularly scheduled appointment because the condition has the potential to worsen without timely medical intervention. Examples are:

Most broken bone cases	Dehydration
Sprains	Convulsions
Fevers	Most allergic drug reactions
	Non-severe bleeding

Unless you get approval from [Contractor's name], you must receive Urgent Care from a [Contractor's name] Provider. If you receive services from non-[Contractor's name] Providers, you may have to pay for them.

Regular care if you are out-of-town

The rules about Emergency and Urgent Care are the same everywhere you go.

[Contractor's name] will only pay for Routine Care while you are out of the [Contractor's name] Primary Care Network if you get [Contractor's name] approval. This means that you cannot get Routine Care without [Contractor's name] approval when you are on a trip. Children who spend time away from home and out of the [Contractor's name] Primary Care Network will have care paid for if [Contractor's name] approves the service.

If you are going to move to a new county, contact [Contractor's name] and your local county office. Depending on your new county, you may need to change managed care plans.

Other Medicaid Covered Services

The Medicaid program will pay for the services listed below, not [Contractor's name]. [Contractor's name] will help you to arrange for these services. If you need these services, call [Contractor's name] at [phone number] for help in making an appointment.

1. School-based health services for Children who are in special education programs;

2. Intermediate care facilities services for the developmentally disabled;

3. Dental services and dentures for adults 21 years of age and older;

4. Dental and orthodontic services for Children and adults up to 21 years of age;

5. Prescribed drugs;

6. Optometric services and eyeglasses;

7. Nursing facility and swing-bed services;

8. Indian Health Service clinic and hospital services;

9. Medicare and group health insurance premiums;

10. Home and community-based services for the elderly, disabled, traumatically brain injured, and mentally retarded; and

11. Private duty nursing services.

Disenrollment

You have the right to request disenrollment. Disenrollment may take up to 2 months. Call [Contractor's name] at [phone number] for more information.

ATTACHMENT F: ELIGIBLE GROUPS

1. Except as provided in subsection 2 of this attachment, the following groups of Medicaid eligible individuals may be enrolled in the Medicaid program with Contractor:

   A. All Aid to Families with Dependent Children (AFDC) recipients or Temporary Assistance for Needy Families (TANF) recipients (AFCH, AFCT);

   B. All recipients of extended Medicaid benefits (AFMA, AFMC, AFCH, AFCT);

   C. All Poverty Level children 0 through 18 years of age (PLCH, PLCU, PL6H, PL6U);

   D. All Poverty Level and categorically needy pregnant women (PLPW, AFPW, AFCT);

   E. All optional categorically eligible individuals 0 through 20 years of age (AFPU, AFCT, AFCH, AFCU).

2. Individuals in the aid categories and subcategories are not eligible to enroll in the Medicaid program with Contractor if:

   A. They have Medicare coverage in addition to Medicaid coverage;

   B. They are nursing facility residents, or are otherwise institutionalized in facilities such as intermediate care facilities for the mentally retarded or residential treatment centers;

   C. They are medically needy; or

   D. They are recipients of home and community-based waivered services for the elderly or the disabled.

   E. They are Enrollees under age 19 with special needs that are eligible for SSI, eligible under Section 1902(e)(3) of the Act, or eligible under a Maternal Child Health Services Block Grant.

   F. They are disabled Enrollees.

   G. They are blind Enrollees.

   H. They are aged Enrollees.

   I. They are residents of the North Dakota State Hospital.

   J. They are Enrollees receiving foster care, IV-E and non-IV-E.

   K. They are Enrollees receiving adoption assistance, IV-E and Non-IV-E.

   L. They are Enrollees receiving refugee assistance.

   M. They are Enrollees having a retroactive eligibility period.

ATTACHMENT G: COMPENSATION PAID TO CONTRACTOR

CAPITATION RATE BY AID CATEGORY, AGE AND GENDER

Aid Category	Gender	Age	2006 Per Enrollee Per Month Rate
TANF	F	0-1	$146
		2-5	41
		6-11	45
		12-18	113
		19-21	180
		22-44	197
		45-64	226
	M	0-1	177
		2-5	50
		6-11	70
		12-18	85
		19-21	77
		22-44	139
		45-64	265

Aid Category	Gender	Age	2006 Per Enrollee Per Month Rate
Poverty Level	F	0-1	$314
		2-5	77
		6-11	102
		12-18	134
		19-21	670
		22-44	969
		45-64	1,165
	M	0-1	423
		2-5	107
		6-11	135
		12-18	130
		19-21	212
		22-44	280
		45-64	696

ATTACHMENT H: SPECIFICATIONS FOR THE CONTRACTOR ENROLLMENT NOTIFICATION FILE

Below are the field definitions, field size, and date format when applicable. The fields are printed in the order in which they will appear. Information will be available to be transmitted by the last working day of the month prior to the month for which information is being sent.

Notification for month and year	06(ccyymmdd)
Contractor identification number	09
Contractor name	30
Contractor code	02
TECS recipient case number	10
TECS recipient identification number	10
Enrollee last name	19
Enrollee first name	12
Enrollee middle initial	01
Enrollee SSN (when available)	09
Enrollee sex code	01
Enrollee birthdate	08(ccyymmdd)
Address1	25
Address 2	25
City	16
State	02
State + Zip code + 4	13
Enrollee telephone number (if known)	10
Initial enrollment date	08(ccyymmdd)
Aid category	02
Aid subcategory	02
Filler	10
Provider free choice code	01
TPL coverage type (May repeat up to 10 times)	01
TPL carrier code (May repeat up to 10 times)	04
TPL policy number (May repeat up to 10 times)	15
TPL company name (May repeat up to 10 times)	50
Policy holder last name (May repeat up to 10 times)	17
Policy holder first name (May repeat up to 10 times)	12
Policy holder middle initial (May repeat up to 10 times)	01
TPL start date	08
TPL end date	08

ATTACHMENT I: SPECIFICATIONS FOR DEPARTMENT DRUG FILE

Contractor ID number	09
Recipient last name	19
Recipient first name	12
TECS recipient identification number	10
Recipient date of birth	08
Recipient SSN (when available)	09
National Drug Code Number	11
Drug name	30
Drug strength	10
Drug form	10
Date dispensed	08 (ccyymmdd)
Quantity	07
Days supply	03
Prescriber Provider number	09
Prescriber name	30

ATTACHMENT J: CERTIFICATION REGARDING STERILIZATION CONSENT FORM

Contractor shall use, as a consent form for sterilization procedures performed on Enrollees under this Contract, the form appearing at pages J-2 and J-3, printed front-to-back. The Contractor shall report sterilization and hysterectomies on the form appearing at page J-4.

Plan Name

Federal Utilization Requirements for Sterilizations, Hysterectomies, and Vasectomies Report

Claims paid mm/dd/yyyy - mm/dd/yyyy

Defined as the following Procedure Codes: 58150, 58152, 58180, 58200, 58210, 58525, 58550, 58600, 58670, 58611, 58951, 59100, 51925, 58260-58270, 58275-58280

Defined as the following Diagnosis Codes: V252-V2529, V2651

Enrollee Name	Enrollee ID #	Date of Birth	Consent Form Received	Procedure/Diagnosis Code	Date of Service	Physician/Provider Name

Plan Name

Sterilizations, Hysterectomies, and Vasectomies **Annual** Summary Report

mm/dd/yyyy - mm/dd/yyyy

Enrollees that received Sterilizations, Hysterectomy, Vasectomy: ##

Enrollees that with Consent Forms for Sterilizations, Hysterectomy, Vasectomy: ##

% of Compliance: xxx.x%

COMMENTS / ANALYSIS / ACTION PLAN:

ATTACHMENT K: ENCOUNTER DATA, MANDATORY REPORTS FROM CONTRACTOR AND SELECTED REPORT FORMS

GENERAL REPORT INFORMATION:

1. Information due by 90 Days after the period on which the report is based.
2. Information to be based on date of service.
3. Annual reports will the Department Fiscal Year (July 1 through June 30).
4 Initial reports will cover full Quarters and become annual as of July.
5. Other reports may be required as determined by the Department.
6. The Department may identify specific formats or categories of information for inclusion in reports.
7. The Department may identify specific individuals to whom reports are to be made.

INITIAL AND AS UPDATED REPORTS:

1. Subcontractors (Provider list by name or organization).
2. Copies of ND Department of Insurance Reports or assurance of availability of same, verifying professional liability coverage, bonding Workers Compensation coverage, and unemployment insurance.
3. HCFA Form 1513 Disclosure of Ownership and Control Interest Statement.
4. Disclosure of Interlocking Relationships required by Section 4.3 of Attachment C.
5. Copy of Enrollee Handbook (initially and as updated).
6. Disenrollment requests (within 5 working days).
7. Fraud and abuse information.

MONTHLY REPORTS:

1. Encounter Data.
2. Quality Assurance activities reports as required by Section 2.20(3)(g) of Attachment C for diseases, procedures, and services as determined by the Department.

QUARTERLY REPORTS:

1. Enrollment reports
   a. Average number of enrollees
   b. Unique count/demographics
2. Access reports
3. Marketing Activity
4. Utilization Review
   a. Ambulatory care
   b. Inpatient
   c. DRG report

   d. Prenatal care and births
   e. Immunizations
5. Health Tracks screening/service
   a. Detail
   b. Summary
6. Sterilization and hysterectomies
7. Complaint and Grievances
8. TPL Collections
9. Quality Assurance activities results documentation as required by Section 2.20(3)(h) and (i) of Attachment C

ANNUAL REPORTS:

1. Encounter Data summary - written form
2. Enrollment reports and Enrollment summary
   a. Average number of enrollees
   b. Unique count/demographics
3. Access Summary
4. Marketing Activity summary
5. Utilization Review summaries
   a. Utilization, ambulatory care
   b. Utilization, inpatient
   c. Prenatal care and births
   d. Immunizations
   e. DRG report
   f. Encounter Data summary – written form
6. Health Tracks screening/service summary
7. Sterilization and hysterectomies summary
8. Complaint and Grievances summary
9. TPL Collections summary
10. Subcontractors - Participating Provider list by name or organization
11. Quality assurance summary

General Encounter Data Information

Contractor shall submit Encounter Data electronically to the Department on a monthly basis. The claims must be either a HCFA-1500 claim or UB-92 claim. HCFA-1500 Encounter Data and UB-92 Encounter Data must be submitted in the National Standard Format.

At a minimum, Contractor must complete the following fields in each claim type with valid values as defined by the Department.

Medical Encounters (HCFA-1500):

Performing Provider number (must be Medicaid Provider number; for non-Medicaid Providers, Contractor shall obtain a dummy Provider number from the Department)
Referring Provider number (must be Medicaid Provider number; for non-Medicaid Providers, Contractor shall obtain a dummy Provider number from the Department)
Recipient Medicaid identification (ID) number
Recipient name
Recipient date of birth
Diagnosis code(s)(ICD-9)
Dates of service
Place of service indicator
Procedure codes (CPT-IV and HCPCS) and modifier if applicable
Quantity of service provided by line item
Usual and customary charges by line item

Outpatient hospital encounters (UB-92):

Hospital Provider number (must be Medicare UPIN number)
Referring Provider number (must be Medicare UPIN number)
Recipient Medicaid identification (ID) number
Recipient name
Recipient date of birth
Revenue code(s)
Line item dates of service
Diagnosis code(s)(ICD-9)
Procedure code(s)(CPT-IV and HCPCS)
Number of units and CPT-IV codes for lab and imaging charges
Attending physician Provider number (must be Medicare UPIN)
Bill type
Date of service span AND admission hour
Usual and customary charges

Inpatient hospital encounters (UB-92)

Hospital Provider number (must be Medicare UPIN number)
Referring Provider number (must be Medicare UPIN number)
Recipient Medicaid identification (ID) number
Recipient name
Recipient date of birth
Revenue code(s)
Dates of service span and admission hour
Diagnosis code(s)(ICD-9)
DRG number
Procedure code(s)(ICD-9)
Attending physician Provider number (must be Medicare UPIN number)
Bill type
Type of admission
Usual and customary charges
Patient discharge status

Plan Name
Enrollment Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

	Current Quarter	Previous Quarter	Fiscal Year-to-Date
	mm/dd/yyyy - mm/dd/yyyy	mm/dd/yyyy - mm/dd/yyyy	mm/dd/yyyy - mm/dd/yyyy
Average Number of Enrollees	###		

Plan Name
Unique Enrollee Count/ Enrollee Demographics
Claims paid mm/dd/yyyy - mm/dd/yyyy

Unique Number of Contracts/Enrollees		x,xxx	
Male		x,xxx	
Female		x,xxx	
Age 0 to 19	Male	x,xxx	xx.x%
	Female	x,xxx	xx.x%
Age 20 to 34	Male	x,xxx	xx.x%
	Female	x,xxx	xx.x%
Age 35 to 44	Male	x,xxx	xx.x%
	Female	x,xxx	xx.x%
Age 45 to 54	Male	x,xxx	xx.x%
	Female	x,xxx	xx.x%
Age 55 & Over	Male	x,xxx	xx.x%
	Female	x,xxx	xx.x%
Unique Enrollees seeing more than one Provider		x,xxx.x	

Plan Name
Access Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

Primary Care Location	# of Primary Care Providers at PCL	# of 'Plan Name' Enrollees seen at PCL during reporting period
"PCL name"	FM: ## IM: ## PEDS: ## OB/GYN ## NP/PA: ##	#,###
(repeat as necessary)		

Unique Enrollees seeing more than one Provider x,xxx.x

COMMENTS / ANALYSIS / ACTION PLAN:

Plan Name
Outreach or Marketing Report
mm/dd/yyyy - mm/dd/yyyy

NARRATIVE

Plan Name
Utilization - Ambulatory Care Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

	Current Quarter mm/dd/yy - mm/dd/yy		Previous Quarter mm/dd/yy - m/dd/yy		Fiscal Year-to-Date mm/dd/yy - mm/dd/yy	
	Total Services	Services/ 1,000	Total Services	Services/ 1,000	Total Services	Services/1, 000
Clinic Visits						
Outpatient Hospital visits						
Emergency Room Visits						
ER visits resulting in an Admission						
Total						

Plan Name
Utilization - Inpatient Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

	Current Reporting Period					Previous Reporting Period					Fiscal Year to Date				
Inpatient Care	Claims /Admits	Days	ALOS	Days/ 1000	Admits/ 1000	Claims /Admits	Days	ALOS	Days/ 1000	Admits/ 1000	Claims /Admits	Days	ALOS	Days/ 1000	Admits/ 1000
One Day Stays															
Stays Greater than One Day															
Total															
Inpatient Care															
Normal Newborn															
Critical Newborn															
Maternity															
All Other Inpatient															
Total															

Plan Name
Institutional Inpatient DRG Breakdown by Payments
Claims paid mm/dd/yyyy - mm/dd/yyyy

	DRG	Description	Provider Name	Billed Amount	Other Paid	Paid Amount	Days	Discharges	Transfers
Totals									

Plan Name
Prenatal Care / Birth Weight Report
mm/dd/yyyy - mm/dd/yyyy

Birth Weight	AltruCare Enrollees	Average LOS
# of Live Births	xxx	xx.x
Live Births weighing <1,500 grams	xxx	xx.x
Live Births weighing 1,500 - 2,500 grams	xxx (xx%)	xx.x
Cesarean Section Rate	xxx (xx%)	xx.x

Prenatal Care	AltruCare Enrollees	Average LOS
# of women that had a live birth	xxx	xx.x
# of women who had an OB visit during the 1st trimester	xxx	xx.x
# of women who had an OB visit during the 2nd trimester	xxx (xx%)	xx.x
# of women who had an OB visit during the 3rd trimester	xxx (xx%)	xx.x

COMMENTS / ANALYSIS / ACTION PLAN:

Plan Name
Immunization Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

Compliance	# of enrollees	% of enrollees
Children enrolled age 2 with birthday during reporting period	xxx	xx.x%
Number of enrolled Children who have received the required "full complement" of vaccines by the age of 2 years old	xxx	xx.x%
Number of enrolled Children who have not received the required "full complement" of vaccines by the age of 2 years old	xxx	xx.x%

*North Dakota state law (Chapter 33-06-05-01) requires Children in daycare and schools be age-appropriately immunized against diptheria, tetanus, pertussis, haemphilus influenzae type b, poliovirus, measles, mumps and rubella.

COMMENTS / ANALYSIS / ACTION PLAN:

Plan Name
Detailed Health Tracks Screening/Eligible Children
Claims paid mm/dd/yyyy - mm/dd/yyyy

Enrollee ID #	Enrollee Name	Date of Birth	Date Screened	Performing Physician Name	Lead Screening Y or N	Results of Medical Screening or Types of Referrals Made	Vision (V), Hearing (H) or Dental (D) Check

Plan Name
Summary Health Tracks Screening/Eligible Children
Claims paid mm/dd/yyyy - mm/dd/yyyy

Month	Eligible Children	Children Screened
July yyyy		
August yyyy		
September yyyy		
October yyyy		
November yyyy		
December yyyy		
January yyyy		
February yyyy		
March yyyy		
April yyyy		
May yyyy		
June yyyy		
TOTAL		

Plan Name
Complaint / Grievance Log
mm/dd/yyyy - mm/dd/yyyy

Enrollee Name	Enrollee number	PER number	PCP	Telephone # of PCP	Date of Complaint	Date of Service	Complaint	Status	Action Taken	Date of Resolution

Plan Name
Complaint and Grievance Annual Summary Report
mm/dd/yyyy - mm/dd/yyyy

(list each complaint or grievance as an issue; state the action taken; and the conclusion)

Plan Name
Third Party Liability Report
Claims paid mm/dd/yyyy - mm/dd/yyyy

Amount of third party collections for this Quarter

1. Number of Enrollees	X,XXX
2. Number of Enrollees with third party coverage	X,XXX
3. Number of Enrollees with third party coverage with paid claims	X,XXX
4. Number of total Enrollees with third party collections	X,XXX
5. Total third party collections	$XXX,XXX

Cumulative amount of third party collections for this Fiscal Year-to-date

1. Number of total Enrollees with third party collections	X,XXX
2. Total third party collections	$XXX,XXX

ATTACHMENT L: COVERED SERVICES

1. Ambulance Services - includes emergency ambulance and air transport. Non-emergency ambulance services may be approved if medically necessary. Transportation payment is governed by N.D. Admin. Code §75-02-02-13.1.

2. Ambulatory Surgical Center - includes surgeries at outpatient surgery centers.

3. Chiropractor - services limited to Medically Necessary manual manipulation of the spine and X-Rays limited to the spinal area.

4. Family Planning - includes reproductive health exams, patient counseling and education, necessary laboratory tests, diagnosis of infertility, sterilization procedures as defined by the Department, testing, treatment and counseling for sexually transmitted diseases and family planning supplies. Medicaid Enrollees have the choice to select any family planning Provider without the need to obtain a referral from Contractor. Contractor is required to pay for any Medicaid approved family planning service obtained by an Enrollee.

5. Federally Qualified Health Centers - includes those core services defined in Section 1861 (aa)(1)(A-C) of the Social Security Act {42 U.S.C. § 1395x(aa)(1)(A)-(C)}, services specified in 42 CFR § 405.2416 and 405.2448 and any other ambulatory service covered under the State of North Dakota Medicaid program.

6. Health Tracks - Screening services that include the required elements prescribed in federal regulations. Screening services may be provided directly by Contractor contracted physicians or may be referred to the appropriate public health unit. Screenings conducted by public health units will be paid directly by the Medicaid Program. All Medically Necessary physical or mental conditions discovered during the screening must be treated except for those services specifically identified as non-covered services within this Contract. Services are limited to Children under 21 years of age.

7. Home health care - includes nurse, home health aide, physical therapy, occupational therapy, speech therapy and appropriate medical supplies furnished by a licensed home health agency.

8. Hospice - includes all authorized services provided by a licensed hospice agency.

9. Hospital Services, Inpatient - includes all Medically Necessary inpatient stays including rehabilitation and alcohol and drug detoxification and post-delivery coverage required under N.D.C.C. § 26.1-36-09.8.

10. Hospital Services, Outpatient - includes all Medically Necessary Services provided in an outpatient hospital setting including necessary emergency room services.

11. Immunizations - includes all immunizations recommended by the Advisory Committee on Immunization Practices.

12. Laboratory and X-Ray - includes all Medically Necessary non-hospital laboratory and x-ray services.

13. Mental Health Services - includes (1) inpatient psychiatric services provided in distinct part units of acute care hospitals, (2) institutions for mental diseases including the North Dakota State Hospital for individuals under 22 years of age, (3) partial hospitalization, (4) outpatient hospital psychiatric care, (5) The full range of therapy and rehabilitative services provided by the state of North Dakota operated Regional Human Service Centers, (6) psychologist services, (7) outpatient chemical dependency treatment, and (8) any other appropriate and necessary mental health services.

14. Mid-level practitioner services - includes family and pediatric nurse practitioner and nurse mid-wife services allowed under North Dakota state law.

15. Nutrition Services - includes evaluation and dietary counseling for diabetes, eating disorders including morbid obesity, cardiovascular diseases, phenylketonuria, and renal failure. Prior Authorization is necessary for treatment of other conditions.

16. Occupational therapy - includes therapy ordered by a physician and provided by a licensed therapist.

17. Physical therapy - includes therapy ordered by a physician and provided by a licensed therapist.

18. Physicians - any Medically Necessary Service provided by or under the direct supervision of a licensed physician in accordance with North Dakota law.

19. Podiatry - includes all necessary services of a licensed podiatrist for the treatment of the foot or ankle.

20. Prosthetic devices and durable medical equipment and supplies - includes any medically necessary item that is primarily and customarily used for medical purposes; can withstand repeated use and is ordinarily not useful in the absence of illness, injury or disability. Medical supplies include necessary expendable items such as ostomy supplies, catheters, oxygen, etc.

21. Public Health Units - includes all Medicaid eligible services that are covered at publicly funded health units.

22. Rural health clinics - includes core services as defined in 42 CFR § 440.20(b) and any other ambulatory service that are otherwise covered in the state of North Dakota Medicaid program and provided directly by the rural health clinic.

23. Speech therapy - includes therapy referred by a physician and provided by a qualified therapist. Also includes any necessary hearing devices including hearing aides and batteries.

24. Transplants - includes all covered transplants, standards, and limits as described in the state of North Dakota Medicaid program applying to the fee-for-service Medicaid program. Experimental transplants are not covered.

25. Transportation - includes necessary transportation in order for an Enrollee to secure medical examinations and treatment. Available free transportation services should be used before incurring any transportation expenses. Transportation expenses include cost of transportation, (common carrier, taxi, other appropriate means) meals and lodging en route to and from medical care and while receiving care and the cost of an attendant if necessary. Transportation payment is governed by N.D. Admin. Code §75-02-02-13.1.

ATTACHMENT M: NON-COVERED SERVICES

The following services are NOT COVERED SERVICES under this contract:

1. Abortions.

2. Home and Community-Based Care for the Elderly, Disabled, Traumatic Brain Injured and Developmentally Disabled.

3. Intermediate Care Facilities for the developmentally disabled (ICF-MR).

4. Nursing facility and swing-bed services.

5. Dentistry or dental processes and related charges provided by a Dentist (D.D.S.) or Oral Surgeon. This includes extraction of teeth, dentures, dental appliances, including orthodontia placed in relation to a covered oral surgical procedure, removal of impacted teeth, root canal therapy or procedures relating to the structures supporting the teeth, gingival tissues or alveolar processes and benefits provided to a covered individual requiring hospitalization or general anesthesia for dental care treatment.

6. Optometric services, including eyewear.

7. Drugs.

8. School based special education related services included in a child's Individual Education Plan.

9. Targeted case management services for the severely mentally ill.

10. Indian Health Service hospital or Clinic Services.

11. Treatment services for Children in private facilities.

12. Private duty nursing services.

The following are NOT COVERED SERVICES under Medicaid:

1. Acupuncture.

2. Cosmetic surgery.

3. Experimental services and procedures.

4. Reversal of sterilization.

5. In vitro fertilization and embryo transplantation or implantation.

6. Care by physicians and hospitals who are not Participating Providers with the Contractor (except in emergencies or upon prior approval by the Contractor's Medical Director).

7. Services that are the responsibility of Workers Compensation.

ATTACHMENT N: ENROLLMENT AREA

The Enrollment Area is:

GRAND FORKS COUNTY
PEMBINA COUNTY
WALSH COUNTY

ATTACHMENT O: SERVICE LIMITS

1. Chiropractic manipulation visits – 12 per year
2. Chiropractic x-rays – 2 per year
3. Occupational Therapy Evaluation – 1 per year
4. Occupational Therapy – 20 visits per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.)
5. Psychological Evaluation – 1 per year
6. Psychological therapy visits – 40 per year
7. Psychological testing – four units (hours) per year
8. Speech therapy visits – 30 per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.)
9. Speech evaluation – 1 per year
10. Physical therapy evaluations – 1 per year
11. Physical therapy visits – 15 per year (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.)

Authorizations in excess of the above limits may be granted, when medically necessary, by the Utilization Review process established at the Managed Care Organization.

ATTACHMENT P: LIAISONS

Liaison for the Department is:

_____
Name

_____
Title

_____
Address

_____
Telephone Number

_____
Telefacsimile Number

Liaison for Contractor is:

_____
Name

_____
Title

_____
Address

_____
Telephone Number

_____
Telefacsimile Number